OIG | OFFICE *of the* INSPECTOR GENERAL

Cycle 6
Medical Inspection Report

Avenal State Prison

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Introduction

Pursuant to California Penal Code section 6126 et seq., the Office of the Inspector General (the OIG) is responsible for periodically reviewing and reporting on the delivery of the ongoing medical care provided to incarcerated persons[1] in the California Department of Corrections and Rehabilitation (the department).[2]

In Cycle 6, the OIG continues to apply the same assessment methodologies used in Cycle 5, including clinical case review and compliance testing. These methods provide an accurate assessment of how the institution's health care systems function regarding patients with the highest medical risk who tend to access services at the highest rate. This information helps to assess the performance of the institution in providing sustainable, adequate care.[3]

We continue to review institutional care using 15 indicators, as in prior cycles. Using each of these indicators, our compliance inspectors collect data in answer to compliance- and performance-related questions as established in the *medical inspection tool* (MIT).[4] We determine a total compliance score for each applicable indicator and consider the MIT scores in the overall conclusion of the institution's performance. In addition, our clinicians complete document reviews of individual cases and also perform on-site inspections, which include interviews with staff.

In reviewing the cases, our clinicians examine whether providers used sound medical judgment in the course of caring for a patient. In the event we find errors, we determine whether such errors were clinically significant or led to a significantly increased risk of harm to the patient.[5] At the same time, our clinicians examine whether the institution's medical system mitigated the error. The OIG rates the indicators as **proficient**, **adequate**, or **inadequate**.

The OIG has adjusted Cycle 6 reporting in two ways. First, commencing with this reporting period, we interpret compliance and case review results together, providing a more holistic assessment of the care; and second, we consider whether institutional medical processes lead to identifying and correcting provider or system errors. The review assesses the institution's medical care on both system and provider levels.

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1. In this report, we use the terms *patient* and *patients* to refer to *incarcerated persons*.

2. The OIG's medical inspections are not designed to resolve questions about the constitutionality of care, and the OIG explicitly makes no determination regarding the constitutionality of care the department provides to its population.

3. In addition to our own compliance testing and case reviews, the OIG continues to offer selected Healthcare Effectiveness Data and Information Set (HEDIS) measures for comparison purposes.

4. The department regularly updates its policies. The OIG updates our policy-compliance testing to reflect the department's updates and changes.

5. If we learn of a patient needing immediate care, we notify the institution's chief executive officer.

As in Cycle 5, our office continues to inspect both those institutions remaining under federal receivership and those delegated back to the department. There is no difference in the standards used for assessing a delegated institution versus an institution not yet delegated. At the time of the Cycle 6 inspection of Avenal State Prison (ASP), the receiver had delegated this institution back to the department.

We completed our sixth inspection of ASP, and this report presents our assessment of the health care provided at that institution during the inspection period between June 2020 and November 2020.[6] The data was obtained for ASP and the on-site inspections occurred during the COVID-19 pandemic.[7]

Avenal State Prison, located in the city of Avenal, in Kings County, opened in 1987. ASP is designated as a low-to-medium-security institution and currently provides housing for both general population and sensitive needs yard incarcerated persons. The institution operates seven clinics in which staff handle nonurgent requests for medical services, including six facility clinics and one specialty clinic. ASP also conducts patient screenings in its receiving and release clinic (R&R), treats patients requiring urgent or emergent care in its triage and treatment area (TTA), and houses patients who require assistance with activities of daily living in its outpatient housing unit (OHU). California Correctional Health Care Services (CCHCS) has designated ASP as a *basic care institution*. Basic institutions are located in rural areas, away from tertiary care centers and specialty care providers whose services would likely be used frequently by higher-risk patients. Basic institutions have the capability to provide limited specialty medical services and consultations for a patient population that is generally healthy.

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6. Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include cardiopulmonary resuscitation (CPR) reviews during March 2020, death reviews between December 2019 and September 2020, high-risk reviews between May 2020 and November 2020, transfer reviews between March 2020 and December 2020, and RN sick call reviews between June 2020 and December 2020.

7. As of October 5, 2021, the department reports on its public tracker that 85 percent of its incarcerated population at ASP is fully vaccinated while 52 percent of ASP staff are fully vaccinated: see **https://www.cdcr.ca.gov/covid19/population-status-tracking/**.

Summary

We completed the Cycle 6 inspection of Avenal State Prison (ASP) in April 2021. OIG inspectors monitored the institution's delivery of medical care that occurred between June 2020 and November 2020.

The OIG rated the overall quality of health care at ASP as *adequate.* We list the individual indicators and ratings applicable to this institution in Table 1 below.

Overall Rating
Adequate

Table 1. ASP Summary Table

Ratings

| | Proficient | Adequate | Inadequate |

Health Care Indicators	Cycle 6 Ratings			Change Since Cycle 5*
	Case Review	Compliance	Overall	
Access to Care	Adequate	Adequate	Adequate	↓
Diagnostic Services	Adequate	Inadequate	Adequate	↓
Emergency Services	Adequate	N/A	Adequate	↓
Health Information Management	Adequate	Proficient	Proficient	↑
Health Care Environment	N/A	Inadequate	Inadequate	=
Transfers	Adequate	Inadequate	Adequate	=
Medication Management	Adequate	Inadequate	Inadequate	=
Prenatal and Postpartum Care	N/A	N/A	N/A	N/A
Preventive Services	N/A	Inadequate	Inadequate	↓↓
Nursing Performance	Adequate	N/A	Adequate	=
Provider Performance	Adequate	N/A	Adequate	=
Reception Center	N/A	N/A	N/A	N/A
Specialized Medical Housing	Adequate	Inadequate	Inadequate	↓
Specialty Services	Adequate	Adequate	Adequate	↓
Administrative Operations†	N/A	Adequate	Adequate	↓

* The symbols in this column correspond to changes that occurred in indicator ratings between the medical inspections conducted during Cycle 5 and Cycle 6. The equals sign means there was no change in the rating. The single arrow means the rating rose or fell one level, and the double arrow means the rating rose or fell two levels (green, from *inadequate* to *proficient*; pink, from *proficient* to *inadequate*).

† **Administrative Operations** is a secondary indicator and is not considered when rating the institution's overall medical quality.

Source: The Office of the Inspector General medical inspection results.

To test the institution's policy compliance, our compliance inspectors, (a team of registered nurses) monitored the institution's compliance with its medical policies by answering a standardized set of questions that measure specific elements of health care delivery. Our compliance inspectors examined 394 patient records and 1,033 data points and used the data to answer 93 policy questions. In addition, we observed ASP's processes during an on-site inspection in February 2021. Table 2 below lists ASP's average scores from Cycles 4, 5, and 6.

Table 2. ASP Policy Compliance Scores

Scoring Ranges		
100% – 85.0%	84.9% – 75.0%	74.9% – 0

Medical Inspection Tool (MIT)	Policy Compliance Category	Average Score		
		Cycle 4	Cycle 5	Cycle 6
1	Access to Care	79.4%	90.4%	82.4%
2	Diagnostic Services	82.2%	75.4%	57.5%
4	Health Information Management	68.6%	72.9%	86.0%
5	Health Care Environment	87.3%	52.3%	70.0%
6	Transfers	75.5%	91.4%	70.8%
7	Medication Management	65.6%	65.5%	64.0%
8	Prenatal and Postpartum Care	N/A	N/A	N/A
9	Preventive Services	74.4%	93.8%	71.6%
12	Reception Center	N/A	N/A	N/A
13	Specialized Medical Housing	94.7%	100%	70.0%
14	Specialty Services	83.5%	82.4%	79.2%
15	Administrative Operations	71.6%*	94.4%	80.8%

* In Cycle 4, there were two secondary (administrative) indicators, and this score reflects the average of those two scores. In Cycle 5 and moving forward, the two indicators were merged into one, with only one score as the result.

Source: The Office of the Inspector General medical inspection results.

The OIG clinicians (a team of physicians and nurse consultants) reviewed 47 detailed cases, which contained 850 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection in April 2021 to verify their initial findings. The OIG physicians rated the quality of care for 20 comprehensive case reviews. Of these 20 cases, our physicians rated 17 **adequate** and three **inadequate**. Our physicians identified one adverse event during this inspection.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions, which we report in the 13 health care indicators.[8] Multiple OIG physicians and nurses performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. Our clinicians acknowledged institutional structures that catch and resolve mistakes that may occur throughout the delivery of care. As noted above, we listed the individual indicators and ratings applicable to this institution in Table 1, the ASP Summary Table.

In July 2020, the Health Care Services Master Registry showed that ASP had a total population of 3,330. A breakdown of the medical risk level of the ASP population as determined by the department is set forth in Table 3 below.[9]

Table 3. ASP Master Registry Data as of January 2021

Medical Risk Level	Number of Patients	Percentage
High 1	9	0.3%
High 2	63	1.9%
Medium	1,072	32.2%
Low	2,186	65.6%
Total	3,330	100.0%

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated 01-08-21.

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8. The indicators for **Reception Center** and **Prenatal Care** did not apply to ASP.

9. For a definition of *medical risk*, see CCHCS HCDOM 1.2.14, Appendix 1.9.

Based on staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 4 below, ASP had one vacant executive leadership position, one vacant primary care provider position, one vacant nursing supervisor position, and 11.9 vacant nursing staff positions.

Table 4. ASP Health Care Staffing Resources as of January 2021

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff [†]	Total
Authorized Positions	5	9	9.5	64.5	88
Filled by Civil Service	4	8	8.5	52.6	73.1
Vacant	1	1	1	4	7
Percentage Filled by Civil Service	80.0%	88.0%	89.5%	81.6%	83.1%
Filled by Telemedicine	0	0	0	0	0
Percentage Filled by Telemedicine	0	0	0	0	0
Filled by Registry	0	0	1	19	20
Percentage Filled by Registry	0	0	10.5%	29.5%	22.7%
Total Filled Positions	4	8	9.5	71.6	93.1
Total Percentage Filled	80.0%	88.9%	100.0%	111.0%	105.8%
Appointments in Last 12 Months	0	2	0	9	11
Redirected Staff	2	0	0	0	2
Staff on Extended Leave[‡]	0	0	1	7	8
Adjusted Total: Filled Positions	2	6	8.5	64.6	83.1
Adjusted Total: Percentage Filled	40.0%	66.7%	89.5%	100.2%	94.4%

* Executive Leadership includes the Chief Physician and Surgeon.

[†] Nursing Staff includes the classifications of Senior Psychiatric Technician and Psychiatric Technician.

[‡] In Authorized Positions.

Notes: The OIG does not independently validate staffing data received from the department. Positions are based on fractional time-base equivalents.

Source: Cycle 6 medical inspection preinspection questionnaire received on January 2021, from California Correctional Health Care Services.

Medical Inspection Results

Deficiencies Identified During Case Review

Deficiencies are medical errors that increase the risk of patient harm. Deficiencies can be minor or significant, depending on the severity of the deficiency.

An *adverse event* occurs when the deficiency caused harm to the patient. All major health care organizations identify and track adverse events. We identify deficiencies and adverse events to highlight concerns regarding the provision of care and for the benefit of the institution's quality improvement program to provide an impetus for improvement.[10]

Our case reviewers identified one adverse event at ASP during the Cycle 6 inspection:

- In case 18, the patient had a metal lattice implanted in his heart vessel to increase blood flow and required daily aspirin indefinitely to prevent a blockage. The institution did not ensure the patient received this medication daily. We notified the institution and they rectified the situation by administering the aspirin to the patient daily.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to ASP. OIG clinicians rated all 10 of these indicators **adequate**. The OIG physicians also rated the overall adequacy of care for each of the 20 detailed case reviews they conducted. Of these 20 cases, 17 were **adequate** and three were **inadequate**. In the 850 events reviewed, there were 188 deficiencies, 38 of which the OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at ASP:

- Providers and nurses in the triage and treatment area performed well during urgent and emergent situations by making good assessments and providing appropriate interventions.

- Nurses provided good care for hospital return and transfer patients by assessing patients, reviewing hospital and transfer documents, notifying providers, and scheduling required follow-up appointments.

- Clinic nurses reviewed patient requests for service and performed face-to-face patient assessments within the required time frames.

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10. For a further discussion of an adverse event, see Table A-1.

Our clinicians found ASP could improve in the following areas:

- Providers and nurses should document thoroughly and completely.

- Providers and nurses should ensure patients receive chronic care, newly ordered, and hospital discharge medications without interruption.

- Nurses in specialized medical housing should complete admission assessments timely and notify providers when a patient's medical condition changes.

Compliance Testing Results

Our compliance inspectors assessed 10 of the 13 indicators applicable to ASP. Of these 10 indicators, our compliance inspectors rated one *proficient*, three *adequate*, and six *inadequate*. We tested policy compliance in the **Health Care Environment**, **Preventative Services**, and **Administrative Operations** indicators as these indicators do not have a case review component.

ASP demonstrated a high rate of policy compliance in the following areas:

- Medical staff timely scanned initial health screening forms, requests for health care services, and community hospital discharge reports into patients' electronic medical records.

- Nursing staff reviewed health care services request forms and conducted face-to-face evaluations within required time frames.

ASP demonstrated a low rate of policy compliance in the following areas:

- Providers seldom communicated results of diagnostic services timely. Also, most patient letters communicating these results were missing the date of the diagnostic service, the date of the results, and whether the results were within normal limits.

- Medical staff frequently failed to maintain medication continuity for chronic care patients, patients discharged from the hospital, and patients admitted to a specialized medical housing unit.

- Medical staff did not consistently follow hand hygiene precautions before or after patient encounters.

- Nursing staff did not timely perform the initial assessment of patients admitted to specialized medical housing.

Population-Based Metrics

In addition to our own compliance testing and case reviews, as noted above, the OIG presents selected measures from the Healthcare Effectiveness Data and Information Set (HEDIS) for comparison

purposes. The HEDIS is a set of standardized quantitative performance measures designed by the National Committee for Quality Assurance to ensure that the public has the data it needs to compare the performance of health care plans. Because the Veterans Administration no longer publishes its individual HEDIS scores, we removed them from our comparison for Cycle 6. Likewise, Kaiser (commercial plan) no longer publishes HEDIS scores. However, through the California Department of Health Care Services' *Medi-Cal Managed Care Technical Report,* the OIG obtained Kaiser Medi-Cal HEDIS scores for three of five diabetic measures to use in conducting our analysis, and we present them here for comparison.

HEDIS Results

We considered ASP's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. ASP's results compared favorably with those found in State health plans for diabetic care measures. We list the nine HEDIS measures in Table 5.

Comprehensive Diabetes Care

When compared with statewide Medi-Cal programs (California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal), ASP performed better in two of the three diabetic measures that have statewide comparative data: HbA1c screening and Poor HbA1c control. Kaiser NorCal and Kaiser SoCal outperformed ASP in blood pressure control.

Immunizations

Statewide comparative data were not available for immunization measures; however, we include this data for informational purposes. ASP had a 63 percent influenza immunization rate for adults 18 to 64 years old, and a 73 percent influenza immunization rate for adults 65 years of age and older.[11] The pneumococcal vaccine rate was 53 percent.[12]

Colorectal Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes. ASP had a 76 percent colorectal cancer screening rate.

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11. The HEDIS sampling methodology requires a minimum sample of 10 patients to have a reportable result. The sample for older adults did not include a full sample.

12. The pneumococcal vaccines administered are the 13 valent pneumococcal vaccine (PCV13) or 23 valent pneumococcal vaccine (PPSV23), depending on the patient's medical conditions. For the adult population, the influenza or pneumococcal vaccine may have been administered at a different institution other than the one in which the patient was housed during the inspection period.

Table 5. ASP Results Compared With State HEDIS Scores

HEDIS Measure	ASP Cycle 6 Results*	California Medi-Cal 2018†	California Kaiser NorCal Medi-Cal 2018†	California Kaiser SoCal Medi-Cal 2018†
HbA1c Screening	**100%**	90%	94%	96%
Poor HbA1c Control (>9.0%)‡,§	**0**	34%	25%	18%
HbA1c Control (<8.0%)‡	91%	–	–	–
Blood Pressure Control (<140/90)‡	75%	65%	78%	**84%**
Eye Examinations	30%	–	–	–
Influenza—Adults (18–64)	63%	–	–	–
Influenza—Adults (65+)	73%	–	–	–
Pneumococcal—Adults (65+)‖	53%	–	–	–
Colorectal Cancer Screening	76%	–	–	–

Notes and Sources

* Unless otherwise stated, data were collected in February 2021 by reviewing medical records from a sample of ASP's population of applicable patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.

† HEDIS Medi-Cal data were obtained from the California Department of Health Care Services publication titled, *Medi-Cal Managed Care External Quality Review Technical Report*, dated July 1, 2019–July 30, 2010 (published April 2021).

‡ For this indicator, the entire applicable ASP population was tested.

§ For this measure only, a lower score is better.

Source: Institution information provided by the California Department of Corrections and Rehabilitation. Health care plan data were obtained from the CCHCS Master Registry.

Recommendations

As a result of our assessment of ASP's performance, we offer the following recommendations to the department:

Access to Care

- Medical leadership should identify any challenges in providing timely chronic care follow-up and nurse-to-provider referral appointments and implement remedial measures as appropriate.

- Instead of canceling and rescheduling appointments during a pandemic, CCHCS leadership should consider conducting appointments over the phone.

Diagnostic Services

- Medical leadership should determine the causes of untimely provider reviews of radiology, laboratory, and pathology reports and implement remedial measures as appropriate.

- Laboratory and nursing leadership should ascertain the causes of the lack of timeliness in collecting and reviewing stat laboratory tests. Leadership should implement remedial measures as appropriate.

- Nursing leadership should educate nursing staff to notify providers of stat laboratory results within specified time frames, per CCHCS policy.

Emergency Services

- Nursing leadership should ensure thorough assessments are completed for all emergency and face-to-face encounters.

Health Information Management

- Medical leadership should identify challenges in scanning medical records, labeling medical records, and including medical records in the correct patient's file, and implement remedial measures as appropriate.

- The department should consider adjusting the drop-down menu on the results letter in the EHRS to default to *patient letter* instead of *DDP-Scan*. The department should train providers to generate the results letters appropriately.

- The department should consider developing and implementing a patient results letter template that autopopulates with all elements required per CCHCS policy.

Health Care Environment

- Nursing leadership should consider performing random spot checks to ensure staff follow equipment and medical supply management protocols.

- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.

- Nursing leadership should have nurse supervisors at every clinic review the monthly emergency medical response bag (EMRB) logs to ensure bags are regularly inventoried and sealed.

Transfers

- The department should consider developing and implementing an electronic alert to ensure nurses in receiving and release (R&R) properly complete initial screening questions and follow up as needed, and to ensure providers evaluate patients in the time frame required, based on the patient's clinical risk level.

Medication Management

- Medical and nursing leadership should identify challenges to medication continuity for chronic care, hospital discharge, and specialized medical housing patients and implement remedial measures as appropriate.

Preventive Services

- Nursing leadership should consider developing and implementing measures to ensure nursing staff timely screen patients for tuberculosis (TB) and completely address signs and symptoms.

- Medical leadership should determine the causes of untimely provisions of chronic care vaccinations.

- Medical leadership should ascertain why patients at the highest risk of coccidioidomycosis are not transferred out of the facility in a timely manner, and implement remedial measures as appropriate.

Nursing Performance

- Nursing leadership should provide clear guidance to nursing staff on how to appropriately document incidents, interventions, and communication with providers.

Specialized Medical Housing

- Nursing leadership should ensure nurses complete admission assessments for patients in the OHU within the required time frame.

- Nursing leadership should ensure nurses notify the appropriate staff members when a patient's medical condition changes.

- Nursing leadership should identify challenges in ensuring patients who are admitted into the OHU receive their medications timely upon admission and discharge. Leadership should implement remedial measures as appropriate.

Specialty Services

- Medical leadership should review the causes of untimely provider reviews of specialty reports and implement remedial measures as appropriate

- Medical and nursing leadership should ensure patients transferring into ASP receive their previously scheduled specialty appointments within the required time frames.

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Access to Care

In this indicator, OIG inspectors evaluated the institution's ability to provide patients with timely clinical appointments. Our inspectors reviewed the scheduling and appointment timeliness for newly arrived patients, sick calls, and nurse follow-up appointments. We examined referrals to primary care providers, provider follow-ups, and specialists. Furthermore, we evaluated the follow-up appointments for patients who received specialty care or returned from an off-site hospitalization.

Results Overview

ASP provided good access to care. The institution had a high number of COVID-19 positive patients, which affected the ability of the providers and specialists to perform in-person appointments. Some provider encounters were performed over the phone; providers called into housing units, and custody or nursing staff would facilitate phone contact with the patient. This was a superior alternative to canceling and rescheduling patients. Nurses provided in-person assessments and care when necessary. After reviewing all aspects of access, we rated this indicator as *adequate*.

Case Review and Compliance Testing Results

In case review, our clinicians reviewed 191 provider, nursing, specialty, and hospital events that required the institution to generate appointments. We identified 10 deficiencies relating to this indicator, seven of which were significant.[13]

Access to Clinic Providers

ASP provided good access to clinic providers by generally managing referrals to providers and requests for follow-up appointments with providers. Failure to ensure provider appointment availability can cause lapses in care. We reviewed 84 outpatient provider encounters and identified three deficiencies in case 32 and in the following cases:

- In case 3, the on-call provider requested a provider follow-up appointment within a day for the patient with high blood pressure. However, the appointment did not occur until 10 days later. During the on-site inspection, we discussed this with the scheduling supervisor, who surmised the reason for the delay was there was no provider available.

- In case 38, the clinic nurse documented the patient should be scheduled with the provider within two weeks. However, the nurse did not place the order and the patient never saw the provider.

Overall
Rating
Adequate

Case Review
Rating
Adequate

Compliance
Score
Proficient
(82.4%)

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13. Case reviewers identified deficiencies in cases 3, 10, 12, 15, 23, 32, 33, 37, and 38. Significant deficiencies were identified in cases 3, 10, 15, 23, 33, and 38.

Compliance testing showed good scores with provider follow-up appointments (MIT 1.006, 100%), but low scores with chronic care follow-up appointments (MIT 1.001, 48.0%) and nurse-to-provider sick call referrals (MIT 1.005, 71.4%).

Access to Specialized Medical Housing Providers

ASP ensured patients had access to providers in the outpatient housing unit (OHU). Our case review clinicians reviewed 57 encounters in 11 cases and did not find any deficiencies. ASP providers saw patients regularly and performed admission history and physical examinations within 24 hours of the patient's arrival to the OHU. Compliance testing also found the performance of admission history and physical examinations to be timely (MIT 13.002, 90.0%).

Access to Clinic Nurses

ASP had proficient performance with access to clinic nurses. This was evidenced by compliance testing and case review findings. Compliance testing found nurses reviewed patient requests for service the same day they were received (MIT 1.003, 100%) and completed face-to-face assessments within one business day of reviewing sick call requests (MIT 1.004, 100%). Out of the 35 sick call events reviewed, our case reviewers found only one event in which the face-to-face assessment was late, and it was only late by one day.

The OIG clinicians did not identify any deficiencies with provider-to-nurse referrals or care manager appointments.

Access to Specialty Services

ASP provided good access to specialists. Compliance testing found very good completion of high-priority (MIT 14.001, 86.7%), medium-priority (MIT 14.004, 93.3%), and routine-priority (MIT 14.007, 100%) appointments. Specialist follow-ups also occurred timely for high-priority appointments (MIT 14.003, 100%), medium-priority appointments (MIT 14.006, 83.3%) and routine-priority appointments (MIT 14.009, 100%). Case review clinicians found most specialty appointments took place within requested time frames; we only identified two deficiencies:

- In case 33, the nurse requested a routine optometry consultation for the patient, but this appointment did not occur. During our on-site visit, ASP explained the optometrist was unavailable for a prolonged period of time.

- In case 10, the cardiologist requested a follow-up appointment with the patient after an echocardiogram, but the institution did not ensure the appointment occurred timely.

Follow-Up After Specialty Service

ASP performed well with follow-up after specialty services. Case reviewers found no deficiencies, and compliance testing showed good access to providers after specialty services (MIT 1.008, 83.7%).

Follow-up After Hospitalization

ASP did well in ensuring provider follow-up appointments occurred after hospitalizations. Case reviewers examined six hospital returns and found providers followed up with patients after each return. Compliance testing also performed well with provider follow-up after hospitalization (MIT 1.007, 80.0%).

Follow-up After Urgent or Emergent Care (TTA)

ASP ensured that provider follow-up appointments were scheduled after patients visited the triage and treatment area (TTA). We did not identify any deficiencies with appointment scheduling in this area.

Follow-Up After Transferring Into the Institution

ASP did not perform well with initial appointments for patients transferring into the institution. Compliance testing showed almost half of all patients tested did not have their initial intake appointments (MIT 1.002, 56.0%). In our case reviews, the provider did not see the patient in one of the three transfer-in cases:

- In case 23, the newly transferred patient was scheduled to see the provider for an initial appointment. This appointment was rescheduled several times and the patient was not seen until seven months later. Considering COVID-19 guidelines, this high-risk patient should have been seen within seven days. This was a significant lapse in care.[14]

Clinician On-Site Inspection

Our case review clinicians spoke with ASP's executive leadership, medical and nursing leadership, and schedulers regarding the institution's access to care. ASP's review period took place during the COVID-19 pandemic and the institution experienced two large outbreaks during spring and fall 2020. At one point during the pandemic, almost half of ASP's nursing staff was out; fortunately, registry nurses were available to help.

According to medical leadership, providers are split into two groups, one group to provide on-site care and the other to provide care via phone. Because some ASP providers were high-risk, leadership offered them opportunities to telework.

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14. See https://cchcs.ca.gov/covid-19-interim-guidance/.

Recommendations

- Medical leadership should identify any challenges in providing timely chronic care follow-up and nurse-to-provider referral appointments and implement remedial measures as appropriate.

- Instead of canceling and rescheduling appointments during a pandemic, CCHCS leadership should consider conducting appointments over the phone.

Compliance Testing Results

Table 6. Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter? (1.001) *	12	13	0	48.0%
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	14	11	0	56.0%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003) *	30	0	0	100%
Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004) *	30	0	0	100%
Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter? (1.005) *	10	4	16	71.4%
Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? (1.006) *	1	0	29	100%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007) *	4	1	0	80.0%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,[†]	37	6	2	86.1%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	6	0	0	100%
Overall percentage (MIT 1): **82.4%**				

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

[†] CCHCS changed its specialty policies in April 2019, removing the requirement for primary care physician follow-up visits following specialty services. As a result, we tested MIT 1.008 only for high-priority specialty services or when staff ordered follow-ups. The OIG continued to test the clinical appropriateness of specialty follow-ups through its case review testing.

Source: The Office of the Inspector General medical inspection results.

Table 7. Other Tests Related to Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003) *	N/A	N/A	N/A	N/A
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days? (12.004) *	N/A	N/A	N/A	N/A
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	9	1	0	90.0%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *,†	0	0	10	N/A
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	13	2	0	86.7%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	5	0	10	100%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or the Physician Request for Service? (14.004) *	14	1	0	93.3%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	5	1	9	83.3%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	15	0	0	100%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	9	0	6	100%

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

† CCHCS changed its policies and removed mandatory minimum rounding intervals for patients located in specialized medical housing. After April 2, 2019, MIT 13.003 only applied to CTCs that still had state-mandated rounding intervals. OIG case reviewers continued to test the clinical appropriateness of provider follow-ups within specialized medical housing units through case reviews.

Source: The Office of the Inspector General medical inspection results.

Diagnostic Services

In this indicator, OIG inspectors evaluated the institution's ability to timely complete radiology, laboratory, and pathology tests. Our inspectors determined whether the institution properly retrieved the resultant reports and whether providers reviewed the results correctly. In addition, in Cycle 6, we examined the institution's ability to timely complete and review immediate (stat) laboratory tests.

Results Overview

ASP performed sufficiently in completing and retrieving routine diagnostic tests. Case reviewers and compliance testing found excellent test completion, but room for improvement in diagnostic health information management. Most deficiencies were due to incomplete patient notification letters. Although patients generally received letters, most were missing the date of service. Factoring both compliance testing and case reviews, the OIG rated this indicator ***adequate***.

Case Review and Compliance Testing Results

In case review, our clinicians reviewed 197 diagnostic events and identified 48 deficiencies, two of which were significant. Of those 48 deficiencies, we found 46 related to health information management and two pertaining to diagnostic test completion.[15]

Regarding deficiencies found in health information management, we considered test reports that were never retrieved or reviewed to be a problem as severe as tests that were never performed.

Test Completion

ASP had excellent performance in completing radiology services (MIT 2.001, 100%) and laboratory services (MIT 2.004, 90.0%), but had poor performance in completing stat laboratory services (MIT 2.007, zero). Compliance testing found stat laboratory tests were not collected or received within policy time frames. Our case reviewers identified two deficiencies related to test completion, only one of which was significant:

- In case 15, the provider ordered an electrocardiogram, but did not order the nurse appointment needed to perform the test. As a result, the test was not performed.

Overall
Rating
Adequate

Case Review
Rating
Adequate

Compliance
Score
Inadequate
(57.5%)

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15. Deficiencies in diagnostic services occurred in cases 1, 2, 3, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20. Significant deficiencies were identified in cases 11 and 15.

Health Information Management

ASP staff were prompt in retrieving diagnostic reports, but providers did not always endorse the reports timely.[16] Case reviewers and compliance testing also found providers did not send complete patient notification letters and a significant number were missing elements required by CCHCS policy (MIT 2.003, zero, MIT 2.006, zero).[17] Compliance testing showed excellent provider review of routine laboratory tests (MIT 2.005, 100%), but poor provider review of radiology services (MIT 2.002, 70.0%). The management of stat laboratory tests was also poor (MIT 2.008, 50.0%). In one of two stat laboratory compliance samples, the nurse did not notify the provider within the required time frame and the provider did not acknowledge the test timely.

ASP's retrieval of pathology reports was excellent (MIT 2.010, 100%). Providers reviewed and endorsed pathology reports timely (MIT 2.011, 80.0%), but did not send any patient notification letters (MIT 2.012, zero). The providers did not send letters for test and pathology results.

Clinician On-Site Inspection

Our case reviewers discussed the deficiencies with the laboratory supervisors during our on-site inspection. The supervisors explained both deficiencies were due to either incomplete orders, or incorrect prioritization of tests providers ordered.[18]

Recommendations

- Medical leadership should determine the causes of untimely provider reviews of radiology, laboratory, and pathology reports and implement remedial measures as appropriate.

- Laboratory and nursing leadership should ascertain the causes of the lack of timeliness in collecting and reviewing stat laboratory tests. Leadership should implement remedial measures as appropriate.

- Nursing leadership should educate nursing staff to notify providers of stat laboratory results within specified time frames, per CCHCS policy.

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16. Late provider endorsements were identified in cases 7, 12, 14, 18, and 19.

17. Incomplete patient notification letters were identified in cases 1, 2, 3, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 18, and 20.

18. The deficiencies occurred in cases 12 and 15.

Compliance Testing Results

Table 8. Diagnostic Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001) *	10	0	0	100%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	7	3	0	70.0%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	0	10	0	0
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004) *	9	1	0	90.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	10	0	0	100%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	0	10	0	0
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007) *	0	2	0	0
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008) *	1	1	0	50.0%
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	2	0	0	100%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	10	0	0	100%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	8	2	0	80.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	10	0	0
Overall percentage (MIT 2): **57.5%**				

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Overall
Rating
Adequate

Case Review
Rating
Adequate

Compliance
Score
(N/A)

Emergency Services

In this indicator, OIG clinicians evaluated the quality of emergency medical care. Our clinicians reviewed emergency medical services by examining the timeliness and appropriateness of clinical decisions made during medical emergencies. Our evaluation included examining the emergency medical response, cardiopulmonary resuscitation (CPR) quality, triage and treatment area (TTA) care, provider performance, and nursing performance. Our clinicians also evaluated the Emergency Medical Response Review Committee's (EMRRC) ability to identify problems with its emergency services. The OIG assessed the institution's emergency services through case review only; we did not perform compliance testing for this indicator.

Results Overview

Similar to Cycle 5, ASP performed satisfactorily for emergency care. Providers delivered good care for urgent and emergent situations, including after hours. The institution's nursing staff provided good emergency care and our case reviewers identified only two significant nursing deficiencies. Most deficiencies were related to documentation, which did not affect overall patient care. The OIG rated this indicator *adequate*.

Case Review Results

Our clinicians reviewed 28 urgent or emergent events identified within 16 cases and found 29 deficiencies, six of which were significant.[19]

Emergency Medical Response

Overall, ASP staff had appropriate emergency medical responses. First responders evaluated the patient and situation, notified clinical health care staff within the required time frame, and notified emergency medical services (EMS) without delay. Our clinicians reviewed 14 events that involved a first medical responder and identified documentation deficiencies.[20] These deficiencies in documentation did not affect the overall patient care.

In one case in which the patient required cardiopulmonary resuscitation (CPR), staff initiated CPR immediately and provided appropriate and timely interventions. We did not identify any significant deficiencies.[21]

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19. For emergency care, we reviewed cases 1, 2, 3, 4, 5, 6, 7, 10, 12, 14, 15, 16, 17, 18, 20, and 21. Deficiencies occurred in cases 1, 3, 4, 5, 6, 7, 10, 12, 15, 16, 17, 18, and 21. Significant deficiencies occurred in cases 4, 7, 10, 15, and 21.

20. First responder documentation deficiencies occurred in cases 4, 6, and 10.

21. The patient in case 6 required CPR.

Provider Performance

ASP providers performed well with urgent and emergent situations, and after-hours care. Providers considered diagnoses appropriately, but did not always document phone interactions in cases 5, 7, 12, and 18. We also identified three significant deficiencies in which providers deferred care to other staff:

- In case 7, the patient's blood pressure was significantly elevated; however, the on-call provider did not request a repeat blood pressure check.

- In case 15, the nurse noted the patient had high blood pressure and contacted the provider. The provider reviewed the patient's clinical status and electrocardiogram (EKG). The provider documented the patient may have had a heart attack, but did not order cardiac medications.

- In case 21, the patient had an abnormal EKG and experienced symptoms of dizziness, nausea, and vomiting. The provider was notified about the patient's condition, but did not document any treatment plans. Another provider took over the patient's care two hours later. A two-hour delay in an urgent situation is below the standard of care.

Although the deficiencies in these cases did not result in poor outcomes, they put patients at risk.

Nursing Performance

Our case reviewers found nurses in the TTA frequently performed well with assessments, interventions, and provider notifications. Of the six significant deficiencies our clinicians identified, only two were related to nursing:

- In case 4, the nurse only administered one dose of Nitroglycerin to the patient with continued chest pain.[22] However, nursing protocol for chest pain allows up to three doses of Nitroglycerin. Since the patient continued to have chest pain, the nurse should have administered another dose.

- In case 10, the nurse did not thoroughly assess a patient who had unresolved chest pain.

Nursing Documentation

Nurses in the TTA usually performed thorough documentation for emergent events. Although documentation was lacking for timelines, orders, medication administration, pain level assessment, and

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22. Nitroglycerin is a medication administered under the tongue to relieve chest pain.

intravenous line (IV) sites, we identified no pattern of deficiencies.[23] Furthermore, these deficiencies did not affect overall patient care.

Emergency Medical Response Review Committee (EMRRC)

Our clinicians reviewed 11 EMRRC cases.[24] Although the committee performed timely reviews of emergency events, they did not always recognize deficiencies such as incomplete documentation of timelines, medication administration, and any delays in patient transportation to the TTA.

Clinician On-Site Inspection

The TTA had two beds and was staffed with two registered nurses (RNs) during each shift. Providers were assigned to work in the TTA Monday through Friday on a weekly rotational basis. An on-call provider was available after hours, on weekends, and on holidays. The TTA was well-equipped with the required emergency equipment and two emergency response vehicles. Licensed vocational nurses (LVNs) were the first responders on second and third watch and the TTA RN was the first responder on first watch. The TTA staff reported a good rapport with custody staff.

Recommendations

- Nursing leadership should ensure thorough assessments are completed for all emergency and face-to-face encounters.

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23. Deficiencies in TTA nursing documentation occurred in cases 1, 3, 4, 5, 10, 16, and 18.

24. EMRRC cases include cases 1, 2, 3, 4, 5, 6, 10, 15, 16, 17, and 18.

Health Information Management

In this indicator, OIG inspectors evaluated the flow of health information, a crucial link in high-quality medical care delivery. Our inspectors examined whether the institution retrieved and scanned critical health information (progress notes, diagnostic reports, specialist reports, and hospital discharge reports) into the medical record in a timely manner. Our inspectors also tested whether clinicians adequately reviewed and endorsed those reports. In addition, our inspectors checked whether staff labeled and organized documents in the medical record correctly.

Results Overview

In both compliance testing and case review, ASP performed well in health information management. Case reviewers found excellent performance with hospital discharge and specialty reports, but ASP had room for improvement with diagnostic health information management. Compliance testing showed good management of hospital discharge reports, but ASP had room for improvement with specialty report endorsement, stat laboratory report notification, and report scanning. In this indicator, our compliance testing showed a proficient rating, while our case review analysis found an adequate rating. After reviewing all aspects, we rated this indicator *proficient*.

Case Review and Compliance Testing Results

In case review, our clinicians reviewed 849 events and found 62 deficiencies related to health information management. Of these 62 deficiencies, four were significant.[25]

The OIG clinicians discussed health information management processes with ASP health information management supervisors, ancillary staff, diagnostic staff, nurses, and providers. Although we found a pattern of incomplete patient notification letters, providers reported they believed letters automatically included all required elements.

Hospital Discharge Reports

ASP staff timely retrieved, scanned, and reviewed hospital records properly. Our case reviewers examined 15 off-site emergency department and hospital visits and found no deficiencies pertaining to the management of discharge reports. Compliance testing also showed the institution demonstrated excellent management of hospital discharge reports. ASP retrieved and scanned every hospital discharge record (MIT 4.003, 100%) and included a discharge summary in most hospital records (MIT 4.005, 80.0%).

Overall Rating
Proficient
Case Review Rating
Adequate
Compliance Score
Proficient (86.0%)

25. Deficiencies occurred in cases 1, 2 3, 5, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, and 47. Significant deficiencies occurred in 7, 11, and 21.

Specialty Reports

ASP did not perform well in managing specialty reports. Compliance testing showed satisfactory retrieval of specialty reports (MIT 4.002, 83.3%), but untimely provider endorsement of high-priority, medium-priority, and routine-priority specialty reports (MIT 14.002, 46.7%, MIT 14.005, 85.7%, and MIT 14.008 64.3%).

Our clinicians reviewed 36 specialty reports and identified 14 deficiencies.[26] Four deficiencies were due to providers endorsing specialty reports outside policy time frames, as illustrated in the case below:

- In case 7, the patient went to the gastroenterologist. This specialist's report was not retrieved and scanned into the electronic health record system until after the OIG notified ASP of the deficiency.

We also discuss these findings in the **Specialty Services** indicator.

Diagnostic Reports

ASP had mixed performance in the management of diagnostic reports. Compliance testing found poor notification of stat laboratory reports (MIT 2.008, 50.0%) and communication of pathology results (MIT 2.012, zero), but reasonable review of the pathology results (MIT 2.011 80.0%).

Case reviewers examined 201 diagnostic events and found 48 deficiencies related to health information management. Most deficiencies were due to incomplete patient notification letters. Only five deficiencies were due to delayed provider endorsements of the diagnostic reports.

Urgent and Emergent Records

OIG clinicians reviewed 45 emergency care events and found nurses documented these events well. Providers generally documented emergency care sufficiently; however, we identified four minor lapses in documentation. The **Emergency Services** indicator provides additional details.

Scanning Performance

ASP also had mixed performance with the scanning process. Compliance testing showed poor performance with scanning, labeling, and filing reports (MIT 4.004, 66.7%). Patient letters were generated incorrectly and saved as a *DDP-Scan* instead of as a *patient letter*.[27] However, case

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26. Specialty health information management deficiencies occurred in cases 5, 7, 15, 19, 20, and 21. Significant deficiencies occurred in cases 7 and 21.

27. DDP stands for Developmental Disability Program.

reviewers examined over 800 events and did not find any deficiencies with scanning performance.

Recommendations

- Medical leadership should identify challenges in scanning medical records, labeling medical records, and including medical records in the correct patient's file, and implement remedial measures as appropriate.

- The department should consider adjusting the drop-down menu on the results letter in the EHRS to default to *patient letter* instead of *DDP-Scan*. The department should train providers to generate the results letters appropriately.

- The department should consider developing and implementing a patient results letter template that autopopulates with all elements required per CCHCS policy.

Compliance Testing Results

Table 9. Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Are health care service request forms scanned into the patient's electronic health record within three calendar days of the encounter date? (4.001)	20	0	10	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	25	5	15	83.3%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	5	0	0	100%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004) *	16	8	0	66.7%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005) *	4	1	0	80.0%
Overall percentage (MIT 4): **86.0%**				

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Table 10. Other Tests Related to Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	7	3	0	70.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	10	0	0	100%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008) *	1	1	0	50.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	10	0	0	100%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	8	2	0	80.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	10	0	0
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	7	8	0	46.7%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	12	2	1	85.7%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	9	5	1	64.3%

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Overall
Rating
Inadequate

Case Review
Rating
(N/A)

Compliance
Score
Inadequate
(70.0%)

Health Care Environment

In this indicator, OIG compliance inspectors tested clinics' waiting areas, infection control, sanitation procedures, medical supplies, equipment management, and examination rooms. Inspectors also tested clinics' ability to maintain auditory and visual privacy for clinical encounters. Compliance inspectors asked the institution's health care administrators to comment on their facility's infrastructure and its ability to support health care operations. The OIG rated this indicator solely on the compliance score, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

Results Overview

ASP's performance improved from its Cycle 5 inspection. However, various aspects of the institution's health care environment still needed improvement: multiple clinics contained expired medical supplies; multiple clinics contained noncalibrated or nonfunctional equipment; inventories were not performed for emergency medical response bags (EMRBs) or logs were missing staff verification; and staff did not regularly sanitize their hands before or after examining patients. These factors resulted in an *inadequate* rating for this indicator.

Compliance Testing Results

Outdoor Waiting Areas

We examined outdoor patient waiting areas (see Photo 1, below). According to staff, existing waiting areas had sufficient seating capacity and were only used to practice social distancing when indoor waiting areas were at capacity. Furthermore, they only called patients close to their appointment times during inclement weather.

Photo 1. F yard clinic outdoor waiting area (photographed on February 4, 2021).

Indoor Waiting Areas

We inspected indoor waiting areas. Health care custody staff reported that existing waiting areas had sufficient seating capacity. During our inspection, we did not observe overcrowding or noncompliance with social distancing requirements in any of the clinics' indoor waiting areas. The institution also had signs posted with instructions to leave the bench empty in order to maintain six feet of social distancing between patients (see Photo 2, below).
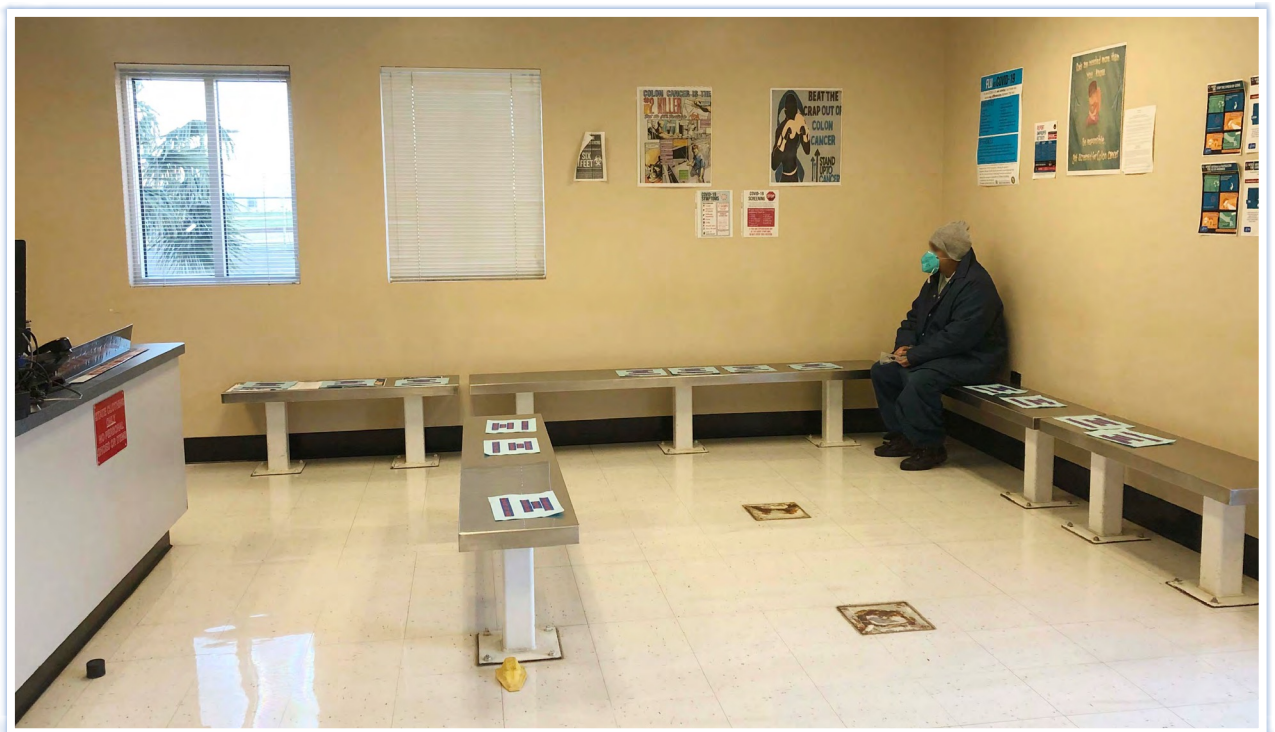

Photo 2. F yard clinic indoor waiting area (photographed on February 4, 2021).

Clinic Environment

All clinic environments were sufficiently conducive for medical care; they provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and staff workspace (MIT 5.109, 100%).

Photo 3. R&R examination room configuration did not have sufficient space for clinicians to conduct proper patient examinations (photographed on February 5, 2021).

Of the 10 clinics we observed, eight contained appropriate space, configuration, supplies, and equipment to allow clinicians to perform proper clinical examinations (MIT 5.110, 80.0%). The remaining two clinics' examination room configurations either did not have sufficient space for clinicians to conduct proper patient examination (see Photos 3, above, and 4, next page) or allow patients to lie fully extended on the examination table without obstruction (see Photo 5, next page).
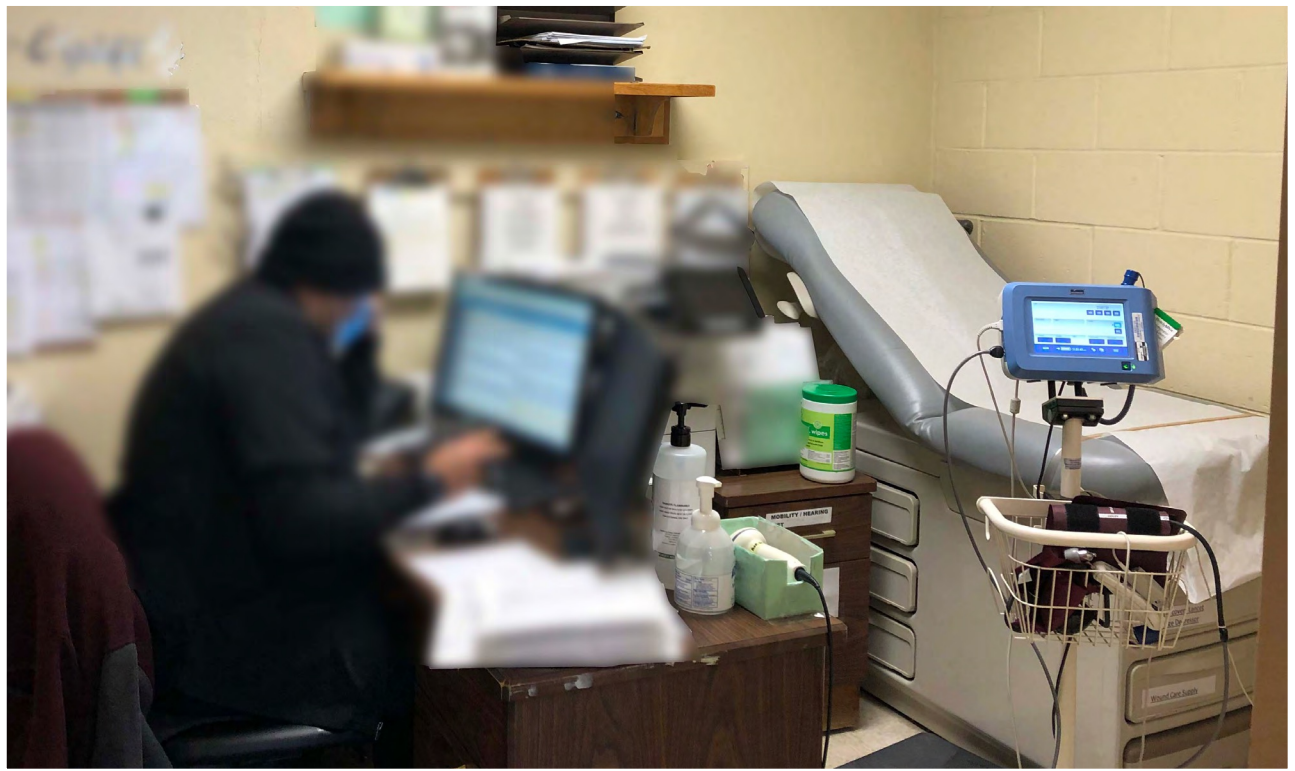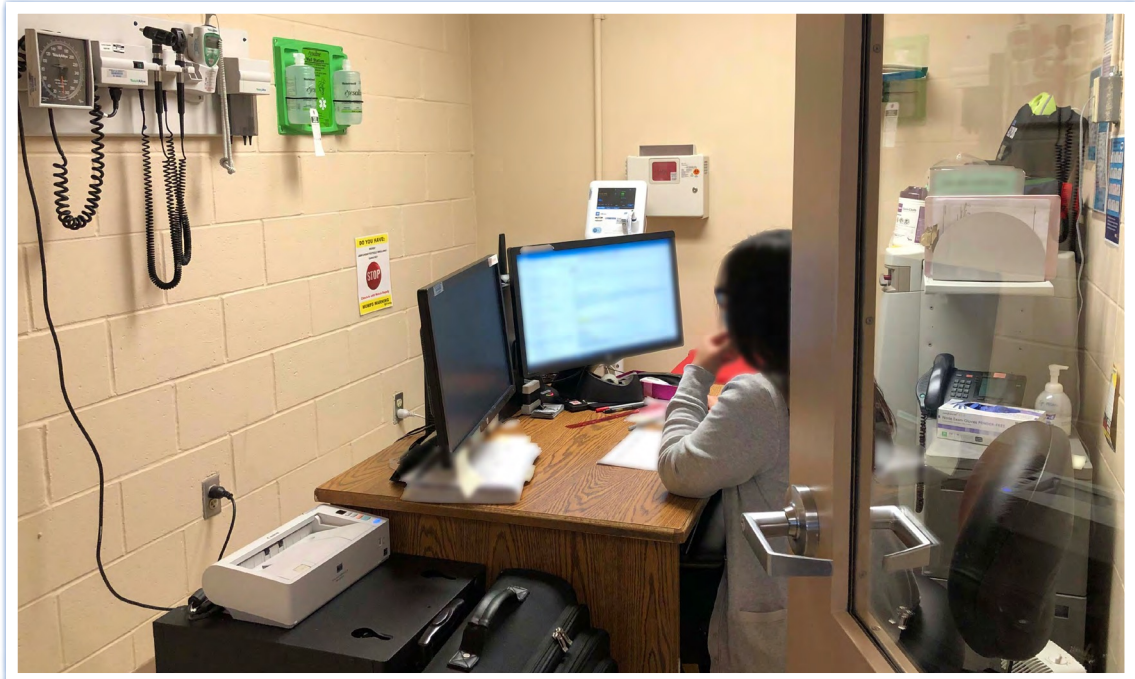
Photo 4. R&R examination room configuration did not have sufficient space for clinicians to conduct proper patient examinations (photographed on February 5, 2021).

Photo 5. D yard examination room configuration did not enable patients to lie fully extended on the examination table without obstruction (photographed on February 4, 2021).

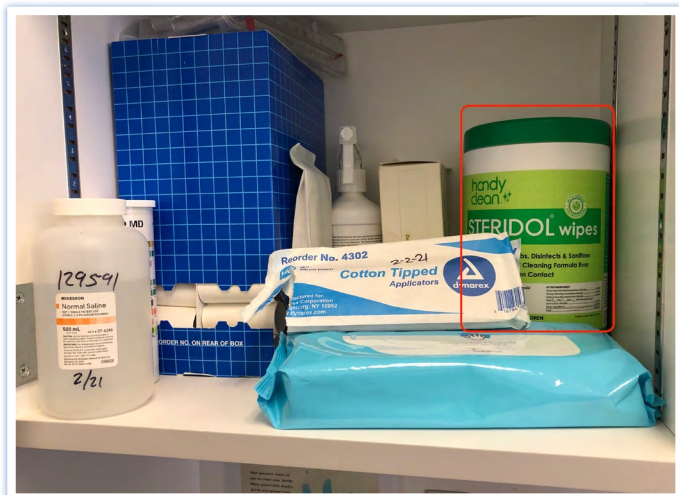Photo 6. TTA clinic expired medical supply, dated February 22, 2020 (photographed on February 2, 2021).

Clinic Supplies

Three of the 10 clinics followed adequate medical supply storage and management protocols (MIT 5.107, 30.0%). We found one or more of the following deficiencies in seven clinics: expired medical supplies (see Photo 6, left), unidentified medical supplies, cleaning materials stored with medical supplies (see Photo 7, below left), compromised sterile medical supply packaging (see Photo 8, below right), and staff members' personal items and food stored with medical supplies.

Four of the 10 clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 40.0%). The remaining six clinics lacked medical supplies or contained improperly calibrated or nonfunctional equipment. The missing items included tongue depressors, hemoccult cards, and disposable paper for the examination table. Staff had not properly calibrated a vital sign machine and weight scale.

Photo 7. E yard clinic medical supplies stored with cleaning supplies (photographed on February 4, 2021).

Photo 8. OHU compromised sterile medical supply packaging (photographed on February 2, 2021).

We found the Snellen reading chart did not have an identified distance line on the floor or wall. We also found nonfunctioning ophthalmoscopes. ASP staff had not properly logged the performance test results of the automated external defibrillator (AED) within the preceding 30 days.

We examined emergency medical response bags (EMRBs) to determine if they contained all essential items. We checked if staff inspected the bags daily and inventoried them monthly. Only one of the eight EMRBs passed our test (MIT 5.111, 12.5%). We found one or more of the following deficiencies with seven EMRBs: staff failed to ensure the EMRB's compartments were sealed and intact, staff had not inventoried the EMRBs when seal tags were replaced, and staff did not seal the main compartment to accommodate the length of the oxygen tank (see Photo 9, below).
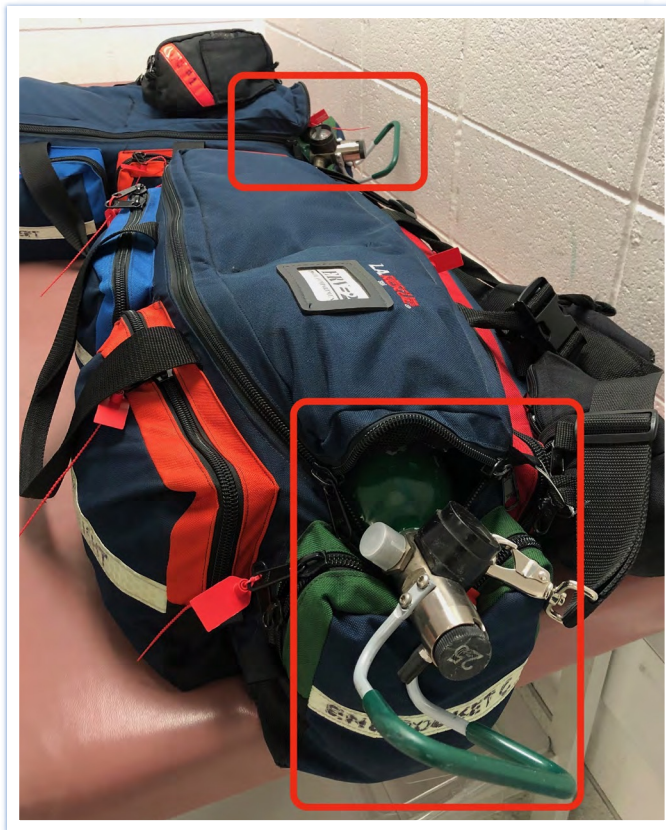

Photo 9. TTA clinic staff did not seal the emergency medical response bag's main compartment to accommodate the length of the oxygen tank (photographed on February 2, 2021).

Medical Supply Management

ASP staff proficiently stored clinic medical supplies in the medical supply storage areas outside the clinics (e.g., warehouse, Conex containers, etc.) (MIT 5.106, 100%).

According to the chief executive officer, the institution did not have any issues with the medical supply process. Health care and warehouse managers expressed no concerns about the medical supply chain or their communication process with the existing system in place.

Infection Control and Sanitation

Staff appropriately disinfected, cleaned, and sanitized nine of 10 clinics (MIT 5.101, 90.0%). In one clinic, cleaning logs were not maintained. Staff in seven of eight clinics properly sterilized or disinfected medical equipment (MIT 5.102, 87.5%). In one clinic, staff did not mention disinfecting the examination table prior to the start of their shift. Instead, staff relied on incarcerated person porters to disinfect the examination rooms prior to the start of their shift.

We found operating sinks and hand hygiene supplies or alcohol-based hand sanitizer in the examination rooms in eight of 10 clinics (MIT 5.103, 80.0%). The patient restrooms in two clinics lacked disposable hand towels.

We observed patient encounters in eight clinics. In four clinics, health care staff did not wash their hands before or after examining patients or before applying gloves (MIT 5.104, 50.0%).

Health care staff in all clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105, 100%).

Physical Infrastructure

The institution's health care management and plant operations manager reported that infrastructures in all clinical areas were in good working order.

At the time of our medical inspection, the institution's administrative team reported no ongoing Health Care Facility Improvement Program construction projects (MIT 5.999).

Recommendations

- Nursing leadership should consider performing random spot checks to ensure staff follow equipment and medical supply management protocols.

- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.

- Nursing leadership should have nurse supervisors at every clinic review the monthly emergency medical response bag (EMRB) logs to ensure bags are regularly inventoried and sealed.

Compliance Testing Results

Table 11. Health Care Environment

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	9	1	0	90.0%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	7	1	2	87.5%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	8	2	0	80.0%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	4	4	2	50.0%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	10	0	0	100%
Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	1	0	0	100%
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	3	7	0	30.0%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	4	6	0	40.0%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	10	0	0	100%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	8	2	0	80.0%
Clinical areas: Are emergency medical response bags and emergency crash carts inspected and inventoried within required time frames, and do they contain essential items? (5.111)	1	7	2	12.5%
Does the institution's health care management believe that all clinical areas have physical plant infrastructures that are sufficient to provide adequate health care services? (5.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
	Overall percentage (MIT 5): **70.0%**			

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

**Overall
Rating**
Adequate

**Case Review
Rating**
Adequate

**Compliance
Score**
Inadequate
(70.8%)

Transfers

In this indicator, OIG inspectors examined the transfer process for those patients who transferred into the institution, as well as for those who transferred to other institutions. For newly arrived patients, our inspectors assessed the quality of health screenings and the continuity of provider appointments, specialist referrals, diagnostic tests, and medications. For patients who transferred out of the institution, inspectors checked whether staff reviewed patient medical records and determined the patient's need for medical holds. They also assessed if staff transferred patients with their medical equipment and gave correct medications before patients left. In addition, our inspectors evaluated the ability of staff to communicate vital health transfer information, such as preexisting health conditions, pending appointments, tests, and specialty referrals; and inspectors confirmed if staff sent complete medication transfer packages to the receiving institution. For patients who returned from off-site hospitals or emergency rooms, inspectors reviewed whether staff appropriately implemented the recommended treatment plans, administered necessary medications, and scheduled appropriate follow-up appointments.

Results Overview

ASP had adequate performance in this indicator. Our clinicians reviewed fewer transfer events due to decreased movement during the COVID-19 pandemic; however, we reviewed the same number of hospitalizations and emergency room visits. Although the number of deficiencies decreased compared with the Cycle 5 inspection, the ratio of cases to deficiencies was almost identical. For the transfer-in process, compliance testing found that when nurses screened patients for tuberculosis, the symptom of fatigue was not assessed. ASP performed well during the transfer-out process. For the hospital return process, the continuity of hospital recommendations and ordered medications needed improvement. Considering the results of both compliance testing and case review, we rated this indicator *adequate*.

Case Review and Compliance Testing Results

In case review, our clinicians reviewed 24 events in 20 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified four deficiencies, two of which were significant.[28]

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28. Deficiencies were identified in cases 10, 18, 23, and 24. Significant deficiencies were identified in cases 10 and 23.

Transfers In

Our case reviewers examined three cases in which patients transferred into ASP from other institutions and identified two deficiencies, only one of which was significant.[29]

Case reviewers identified only one minor deficiency, which was related to the initial health screening; however, the deficiency did not cause harm to the patient. In compliance testing, when evaluating whether nursing staff completed the initial health screening and answered all screening questions within the required time frame, ASP performed poorly (MIT 6.001, zero). Not screening for fatigue as a symptom when assessing patients for tuberculosis was the sole reason most compliance samples failed.[30]

Both case review and compliance testing found ASP performed fairly well in providing medication continuity for patients who arrived from another departmental institution (MIT 6.003, 83.3%). Compliance testing also showed ASP performed well in administering medications without interruption to patients who lay over at the institution (MIT 7.006, 88.9%).

ASP performed well in providing specialty services for newly arrived patients (MIT 14.001, 86.7%).

Compliance testing found providers could improve their performance in seeing newly arrived patients within the required time frame based on the patient's risk level. (MIT 1.002, 56.0%). Case reviewers identified a significant deficiency in provider access:

- In case 23, a high-risk patient transferred into ASP and was scheduled to see the provider. The appointment was rescheduled several times, resulting in the patient not being seen by a provider until seven months after transferring into ASP.

Transfers Out

ASP performed proficiently for patients transferring out of the institution. Case reviewers found patients were screened appropriately, had vital signs checked, and were transferred with all durable medical equipment and medications. Similarly, compliance testing found no deficiencies when reviewing patients who transferred out; all patients had the required documents and medications (MIT 6.101, 100%). We also noted pending appointments were checked and receiving institutions were notified. Nurses documented no medical holds and confirmed with providers when patients were cleared to transfer. R&R nursing staff ensured that all patients transferring out of the institution had the required medications, transfer documents, and assigned durable medical equipment.

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29. Deficiencies occurred in cases 23 and 24. A significant deficiency was identified in case 23.

30. In April 2020, after our review, but before this report was published, CCHCS reported adding the symptom of fatigue into the EHRS PowerForm for tuberculosis symptom monitoring.

Hospitalizations

Patients returning from an off-site hospitalization or emergency room are at high risk for lapses in care. These patients typically experience severe illness or injury, require more care, and place strain on the institution's resources. Because these patients have complex medical issues, the successful transfer of health information is necessary for good quality care. Any lapse of information during transfer can result in serious consequences for these patients.

ASP performed very well in most areas of the hospital return process. Our clinicians reviewed 15 events in which patients returned from either a hospitalization or an emergency room visit. We identified only two deficiencies, one of which was significant.[31]

Case reviewers did not identify any delays with provider follow-up appointments upon a patient's return from a hospitalization. Compliance testing also noted patients received a follow-up appointment within the required time frame most of the time (MIT 1.007, 80.0%).

ASP also performed well in scanning hospital discharge documents into patients' health records within three calendar days (MIT 4.003, 100%). Furthermore, compliance testing found that key elements were included in the final hospital discharge reports and that primary care providers reviewed the reports within five calendar days of a patient's discharge. (MIT 4.005, 80.0%).

The only area ASP had room for improvement was in continuity of hospital-recommended medications. Compliance testing found poor performance in ensuring hospital-recommended medications were administered, made available, and delivered to patients within the required time frames (MIT 7.003, 40.0%). Furthermore, case reviewers identified a significant deficiency:

- In case 10, the patient returned to ASP after being hospitalized for a heart attack. The provider assessed the patient, but did not order the nitroglycerin the hospital recommended, thereby failing to meet community standards.

Clinician On-Site Inspection

OIG clinicians interviewed the R&R nursing staff during the on-site visit. The R&R had two RNs and an office technician on second watch and one RN on third watch. Although first watch was not staffed, nurses flexed their hours to cover buses transferring in and out. R&R staff were knowledgeable about the transfer process, including medication availability, provider appointment timelines, completion of screening questions, and specialty appointment continuity. For patients transferring into ASP, the nurses checked the previous encounters for pending appointments and messaged the yard LVN, the utilization

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31. Deficiencies with hospital returns were identified in cases 10 and 18. A significant deficiency was identified in case 10.

manager, and the provider. The nurses used the message board at the receiving facility to communicate information regarding patients with pending specialty appointments who transferred out of ASP. Prior to transfer, the nurses confirmed patients had no medical holds and notified providers to confirm clearance to transfer.

Recommendations

- The department should consider developing and implementing an electronic alert to ensure nurses in receiving and release (R&R) properly complete initial screening questions and follow up as needed, and to ensure providers evaluate patients in the time frame required, based on the patient's clinical risk level.

Compliance Testing Results

Table 12. Transfers

Compliance Questions	Yes	No	N/A	Yes %
	Scored Answer			
For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001) *	0	25	0	0
For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the initial health screening form; refer the patient to the TTA if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening? (6.002)	18	0	7	100%
For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	5	1	19	83.3%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) *	4	0	0	100%
Overall percentage (MIT 6): **70.8%**				

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Table 13. Other Tests Related to Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	14	11	0	56.0%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment with a primary care provider within the required time frame? (1.007) *	4	1	0	80.0%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	5	0	0	100%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005) *	4	1	0	80.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	2	3	0	40.0%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	24	1	0	96.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	8	1	0	88.9%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010) *	1	3	0	25.0%

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Overall
Rating
Inadequate

Case Review
Rating
Adequate

Compliance
Score
Inadequate
(64.0%)

Medication Management

In this indicator, OIG inspectors evaluated the institution's ability to administer prescription medications on time and without interruption. The inspectors examined this process from the time a provider prescribed medication until the nurse administered the medication to the patient. When rating this indicator, the OIG strongly considered the compliance test results, which tested medication processes to a much greater degree than case review testing. In addition to examining medication administration, our compliance inspectors also tested many other processes, including medication handling, storage, error reporting, and other pharmacy processes.

Results Overview

ASP performed poorly in this indicator. The institution had adequate performance in new medication prescriptions and transfer medications, but had room for improvement with chronic care medication continuity, hospital discharge medications, and specialized medical housing medications. After careful consideration of compliance testing and case reviews, we rated this indicator **inadequate**.

Case Review and Compliance Testing Results

In case review, our clinicians reviewed 134 encounters related to medications and found 13 deficiencies related to medication management, four of which were significant.[32]

New Medication Prescriptions

ASP generally ensured that patients received their new prescriptions. Compliance testing showed most new prescriptions were given to the patient timely (MIT 7.002, 84.0%). Case reviewers only found one significant deficiency:

- In case 18, the patient with a history of a heart attack and cardiac stent did not receive his aspirin dose while in the outpatient housing unit (OHU).

Chronic Medication Continuity

ASP had a mixed performance in the management of chronic care medications. Compliance testing showed poor performance with chronic care medication continuity (MIT 7.001, 4.6%). Case review clinicians identified four deficiencies, one of which was significant. Most deficiencies were one-day delays of chronic medication administration, except in the following case:

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32. Deficiencies occurred in cases 5, 7, 10, 11, 12, 13, 14, 15, and 18. Cases 10, 12, and 18 had significant deficiencies.

- In case 18, to reduce clotting risk after a recent cardiac procedure, the patient was prescribed aspirin. The provider renewed this medication, but did not ensure the patient received it daily.

Hospital Discharge Medications

ASP did not always ensure patients received their needed medications when they returned from an off-site hospital or emergency room. Compliance testing showed patients received less than half of their discharge medications upon returning to ASP from an off-site hospitalization or emergency department visit (MIT 7.003, 40.0%). Our case reviewers found one significant deficiency in which the patient did not receive the recommended medication:

- As mentioned above in case 18, the patient was discharged from the hospital after a cardiac procedure. The patient did not receive his prescribed aspirin while he was in the outpatient housing unit (OHU).

Specialized Medical Housing Medications

ASP did not always ensure patients received their needed medications when staff admitted them to the OHU. Compliance testing showed poor performance managing admission medications in specialized medical housing (MIT 13.004, 50.0%). Our clinicians reviewed 15 OHU admissions and found only one deficiency.

Transfer Medications

ASP performed very well in managing transfer medications. Compliance testing found good performance in managing medications for new arrivals (MIT 6.003, 83.3%), for intra-facility and yard-to-yard transfers (MIT 7.005, 96.0%), and for transfer layover patients (MIT 7.006, 88.9%). ASP had excellent performance providing complete transfer packets (MIT 6.101, 100%). Case review did not identify any deficiencies in this area. More details are provided in the **Transfers** indicator.

Medication Administration

ASP performed well in administering medications. Compliance testing showed excellent continuity of TB medications (MIT 9.001, 100%) and acceptable TB medication monitoring (MIT 9.002, 75.0%). Case reviewers found nurses administered medications properly. The institution adequately stored and secured narcotic medications in seven of eight clinic and medication line locations (MIT 7.101, 87.5%). In one location, the medication nurse answered a question incorrectly when interviewed regarding the narcotic discrepancy reporting process.

ASP appropriately stored and secured nonnarcotic medications in seven of eight clinic and medication line locations (MIT 7.102, 87.5%). In

one location, there was no identifiable designated area for refrigerated medications to be returned to the pharmacy.

Staff kept medications protected from physical, chemical, and temperature contamination in four of the eight clinic and medication line locations (MIT 7.103, 50.0%). In two locations, staff did not consistently record the room and refrigerator temperatures. In two other locations, staff stored medications with disinfectants.

Staff successfully stored valid, unexpired medications in six of the eight applicable medication line locations (MIT 7.104, 75.0%). In one location, nurses did not label the multi-use medication as per CCHCS policy. In another location, we found expired medication.

Nurses exercised proper hand hygiene and contamination control protocols in five of six locations (MIT 7.105, 83.3%). In one location, nurses neglected to wash or sanitize their hands before each subsequent regloving.

Staff in four of six medication preparation and administration areas demonstrated appropriate administrative controls and protocols (MIT 7.106, 66.7%). In one location, nurses did not maintain unissued medication in its original labeled packaging. In another location, nurses could not explain the process for reconciling new medications received from the pharmacy with the physicians' orders.

Staff in four of six medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 66.7%). In two clinics, nurses did not disinfect the insulin port before drawing medication for injection administration.

Pharmacy Protocols

Pharmacy staff followed general security, organization, and cleanliness management protocols in ASP's main and remote pharmacies (MIT 7.108, 100%) and properly stored nonrefrigerated medications (MIT 7.109, 100%).

The pharmacy did not have an identifiable designated area for refrigerated medications to return to the pharmacy. As a result, ASP scored zero for this test (MIT 7.110).

The pharmacist-in-charge (PIC) did not adequately manage narcotic medications stored in ASP's pharmacy. The PIC did not complete a monthly physical inventory of controlled substances in each automated dispensing cabinet or Omnicell.[33] Furthermore, the PIC did not correctly review monthly inventories of controlled substances in the institution's clinic and medication storage locations. Specifically, the PIC and clinic staff did not correctly complete several medication area inspection checklists (CDCR form 7477). These errors resulted in a score of zero for this test (MIT 7.111).

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33. An Omnicell is an automated medication-dispensing cabinet system.

We examined 19 medication error reports. The PIC timely or correctly processed only 11 of these 19 reports (MIT 7.112, 57.9%). The PIC had no evidence a pharmacy error follow-up review was performed for six medication errors. For one medication error, the PIC did not complete the pharmacy error follow-up review within the required time frame; it was three days late. For the remaining medication error, the PIC had no evidence the pharmacy follow-up review was performed within the required time frame.

Clinician On-Site Inspection

We discussed medication management issues with the PIC, nursing supervisors, medical leadership, and providers. We toured medication lines and interviewed nurses who administered medications. Rooms with medication lines were clean and organized. Medical staff responded to emergencies as first responders and emergency response equipment was readily available. Nurses were familiar with medication processes and policies. Staff reported keep-on-person (KOP) medications were provided on third watch.[34] Nurses explained they sent lists to the housing units of patients who had KOP medication to pick up and called custody and housing units for any patient who did not arrive timely. There was no backlog of KOP medications. Staff said they were familiar with the patient population and would communicate noncompliance of medication during huddles or by messaging the provider. Nurses reported satisfaction with leadership, co-workers, and their working environment. Nurses had a good rapport with custody staff.

Nonscored Tests

In addition to testing ASP's self-reported medication errors, our inspectors also followed up on any significant medication errors found during compliance testing. We did not score this test; we provide these results for informational purposes only. At ASP, we did not find any applicable medication errors (MIT 7.998).

Because ASP did not have restrictive housing units, we did not determine whether patients had immediate access to their prescribed rescue medications (MIT 7.999).

Recommendations

- Medical and nursing leadership should identify challenges to medication continuity for chronic care, hospital discharge, and specialized medical housing patients and implement remedial measures as appropriate.

Table 14. Medication Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows? (7.001) *	1	21	3	4.6%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	21	4	0	84.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	2	3	0	40.0%
For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames? (7.004) *	N/A	N/A	N/A	N/A
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	24	1	0	96.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	8	1	0	88.9%
All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101)	7	1	2	87.5%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution properly secure and store nonnarcotic medications in the assigned storage areas? (7.102)	7	1	2	87.5%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution keep nonnarcotic medication storage locations free of contamination in the assigned storage areas? (7.103)	4	4	2	50.0%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	6	2	2	75.0%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	5	1	4	83.3%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *preparing* medications for patients? (7.106)	4	2	4	66.7%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *administering* medications to patients? (7.107)	4	2	4	66.7%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	0	1	0	0
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	0	1	0	0
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	11	8	0	57.9%
Pharmacy: For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998)	This is a nonscored test. Please see the indicator for discussion of this test.			
Pharmacy: For Information Purposes Only: Do patients in restricted housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications? (7.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
	Overall percentage (MIT 7): **64.0%**			

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Table 15. Other Tests Related to Medication Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	5	1	19	83.3%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) *	4	0	0	100%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) *	4	0	0	100%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) *	3	1	0	75.0%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	5	5	0	50.0%

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Overall
Rating
Inadequate

Case Review
Rating
(N/A)

Compliance
Score
Inadequate
(71.6%)

Preventive Services

In this indicator, OIG compliance inspectors tested whether the institution offered or provided cancer screenings, tuberculosis (TB) screenings, influenza vaccines, and other immunizations. If the department designated the institution as high risk for coccidioidomycosis (valley fever), we tested the institution's ability to transfer patients out quickly. The OIG rated this indicator solely based on the compliance score, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

Results Overview

ASP staff delivered a mixed performance in preventive services. Staff performed well in administering TB medication as prescribed, offering patients an influenza vaccine for the most recent influenza season, and offering colorectal cancer screening for all patients ages 50 through 75. However, they faltered in offering required immunizations to chronic care patients, screening patients annually for TB, and transferring patients who were at the highest risk of coccidioidomycosis (valley fever) infection. These findings are set forth in the table on the next page. We rated this indicator **inadequate**.

Recommendations

- Nursing leadership should consider developing and implementing measures to ensure nursing staff timely screen patients for tuberculosis (TB) and completely address signs and symptoms.

- Medical leadership should determine the causes of untimely provisions of chronic care vaccinations.

- Medical leadership should ascertain why patients at the highest risk of coccidioidomycosis are not transferred out of the facility in a timely manner and implement remedial measures as appropriate.

Table 16. Preventive Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	4	0	0	100%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) †	3	1	0	75.0%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	14	11	0	56.0%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	25	0	0	100%
All patients from the age of 50 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	23	2	0	92.0%
Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006)	N/A	N/A	N/A	N/A
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	N/A	N/A	N/A	N/A
Are required immunizations being offered for chronic care patients? (9.008)	4	2	19	66.7%
Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009)	2	15	0	11.8%
Overall percentage (MIT 9): **71.6%**				

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

† In April 2020, after our review but before this report was published, CCHCS reported adding the symptom of *fatigue* into the electronic health record system (EHRS) PowerForm for tuberculosis (TB)-symptom monitoring.

Source: The Office of the Inspector General medical inspection results.

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Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

Nursing Performance

In this indicator, the OIG clinicians evaluated the quality of care delivered by the institution's nurses, including registered nurses (RNs), licensed vocational nurses (LVNs), psychiatric technicians (PTs), and certified nursing assistants (CNAs). Our clinicians evaluated nurses' ability to make timely and appropriate assessments and interventions. We also evaluated the institution's nurses' documentation for accuracy and thoroughness. Clinicians reviewed nursing performance in many clinical settings and processes, including sick call, outpatient care, care coordination and management, emergency services, specialized medical housing, hospitalizations, transfers, specialty services, and medication management. The OIG assessed nursing care through case review only and performed no compliance testing for this indicator.

When summarizing overall nursing performance, our clinicians understand that nurses perform numerous aspects of medical care. As such, specific nursing quality issues are discussed in other indicators, such as **Emergency Services**, **Specialty Services**, and **Specialized Medical Housing**.

Results Overview

Nurses at ASP generally provided sufficient nursing care. Our findings in this indicator were comparable to those we found in Cycle 5. Most nursing care was appropriate and timely despite the additional responsibilities and added workload arising from the COVID-19 pandemic. The nurses generally performed good patient assessments, provided interventions, and transferred patients to a higher level of care when necessary. Considering all these factors, our clinicians rated this indicator *adequate*.

Case Review Results

We reviewed 220 nursing encounters in 46 cases. Of the nursing encounters we reviewed, 102 were in the outpatient setting. Furthermore, of the 220 nursing encounters, 41 events were directly related to COVID-19 quarantine or isolation rounds.[34] Our clinicians identified 67 nursing performance deficiencies, 10 of which were significant.[35] Fourteen of the deficiencies we identified were related to COVID-19 nursing performance.[36]

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34. COVID-19 rounding is generally performed over a two-week period. Therefore, each *event* reviewed by the OIG case review team included many nursing encounters.

35. Deficiencies related to the quality of nursing care occurred in cases 1, 2, 3, 4, 5, 6, 10, 11, 12, 13, 14, 15, 16, 17, 18, 22, 24, 28, 38, 40, 46, and 47. Significant deficiencies were identified in cases 1, 4, 10, 15, 16, 17, and 18.

36. Deficiencies related to COVID-19 care were identified in cases 1, 2, 4, 10, 12, 14, 15, 16, 17, and 18. Significant deficiencies occurred in cases 1, 4, 10, 15, 17, and 18.

Nursing Assessment and Intervention

ASP nurses generally performed complete and timely assessments and interventions. We identified 20 deficiencies related to inadequate assessments and 12 related to inadequate interventions.[37] Of the deficiencies we identified, 10 were significant, including those in the cases below:

- In case 1, during quarantine surveillance rounds, the patient had a temperature of 103.1 degrees Fahrenheit, chills, cough, diarrhea, headache, and difficulty breathing. The nurse did not perform a patient assessment or document the reassessment of vital signs after administering Tylenol.

- In cases 4 and 18, nurses did not perform COVID-19 isolation rounds as ordered.

- In case 17, for seven out of 14 days, nurses performed isolation rounds only once daily; however, rounds were ordered twice daily.

- Also in case 17, the patient had an elevated heart rate for four days and elevated blood pressure for three days. The nurse did not recheck these abnormal vital signs and did not notify the provider.

- In case 15, for four out of 14 days, nurses performed isolation rounds only once daily; however, rounds were ordered twice daily.

- Also in case 15, the nurse did not check the patient's blood pressure on two rounds, but documented the patient had an elevated heart rate. The nurse did not recheck the patient's heart rate or notify the provider.

Nursing Documentation

Documentation continues to be an area that offers room for improvement for ASP. Of the 67 deficiencies identified for nursing performance, 31 were due to incomplete or inaccurate documentation.[38] Some examples include missing times for emergency events; not documenting all components for IV insertion; documenting inaccurate vital sign entries; and lack of documentation when communicating with providers. While the number of deficiencies was high, the deficiencies were considered minor and did not increase risk of harm to the patient.

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37. Deficiencies due to incomplete assessments were identified in cases 2, 3, 5, 10, 11, 13, 16, 18, 22, 24, 38, and 40.

38. Documentation deficiencies were identified in cases 1, 3, 4, 5, 6, 10, 12, 16, 17, 18, 22, 24, 38, 40, 46, and 47.

Nursing Sick Call

Our clinicians reviewed 41 sick call requests and identified 12 deficiencies.[39] Deficiencies included incomplete assessments, missing or inaccurate documentation, and lack of education or discharge instructions. All deficiencies were minor, with one exception:

- In case 10, the TTA RN reviewed the patient's complaint of shortness of breath and chest pain and completed a phone interview with the patient during the night, but did not perform a face-to-face assessment. Although the patient was previously seen during the day for the chest pain, the patient still had persistent chest pain and should have had a face-to-face assessment by the nurse.

ASP nurses received and reviewed sick calls timely and scheduled appropriate appointments.

Care Management/Coordinator

At ASP, clinic RNs perform both as a primary care clinic nurses triaging sick call requests, performing face-to-face assessments, and as care managers. For patients transferring into ASP, RNs perform initial screenings within 30 days. They also screen patients for hepatitis C and complete chronic care appointments. The clinic LVN staff serve as care coordinators in addition to other duties, such as performing monthly TB screenings, performing blood pressure checks, monitoring the registry for laboratory tests, and distributing diabetic supplies and durable medical equipment.

Wound Care

We reviewed two cases in which nurses provided wound care to patients.[40] Both patients were housed in the OHU, where they received care for up to a month. We identified two minor deficiencies.

Emergency Services

ASP nurses provided good emergency care for patients in the TTA. Staff responded quickly to emergencies, usually provided appropriate interventions, and transferred patients to a higher level of care when needed. We identified two isolated significant deficiencies, one related to assessment and the other related to interventions. Most deficiencies we found were related to documentation and did not affect patient care. Please refer to the **Emergency Services** indicator for more information.

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39. Deficiencies in nursing performance with sick call requests occurred in cases 3, 10, 11, 12, 13, 28, 38, and 40. A significant deficiency was identified in case 10.

40. Wound care was performed in cases 17 and 46. Two minor deficiencies were identified in case 17.

Hospital Returns

ASP performed well in providing nursing care to patients returning from a hospitalization or emergency room evaluation. We reviewed 15 hospital and emergency room returns in 13 cases and identified two deficiencies. All patients returning to ASP from the hospital or emergency room are assessed upon arrival by nurses in the TTA. TTA nurses assessed patients, reviewed hospital documents, notified providers, and placed orders for recommended medications and follow-up care.

Transfers

The institution's nurses provided proficient care for patients transferring into or out of ASP. We reviewed nine events in seven cases that involved the transfer-in or transfer-out process and identified only two deficiencies, one of which was a minor deficiency related to nursing performance.[41] The R&R nurses completed patient screenings, confirmed patients' medications and medical equipment, notified care teams of pending specialty appointments, and scheduled appropriate follow-up care within policy time frames. More details are provided in the **Transfers** indicator.

Specialized Medical Housing

ASP had room for improvement in nursing performance in the OHU. The OIG clinicians reviewed 15 events in nine cases and identified 13 deficiencies related to nursing performance, one of which was significant.[42] This is detailed further in the **Specialized Medical Housing** indicator.

Specialty Services

When patients returned to the institution from a specialty appointment, ASP nurses appropriately assessed the patients, reviewed off-site documents for recommendations, and communicated information to providers. We reviewed 10 events in which patients returned from an off-site specialty procedure or consultation. We identified two minor deficiencies related to nursing performance, both of which were related to documentation errors.[43]

Medication Management

ASP nurses almost always administered medications as required. Our OIG clinicians examined 134 events involving medication management

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41. A minor deficiency related to the quality of nursing care for transfer-in patients was identified in case 24.

42. Deficiencies related to nursing performance in specialized medical housing were identified in cases 2, 5, 10, 12, 16, 17, 18, 46, and 47. A significant deficiency was identified in case 16.

43. We reviewed returns from off-site specialty appointments in cases 5, 6, 15, 17, and 18. Two minor deficiencies were identified in case 5.

and administration. We identified five minor nursing performance deficiencies related to documentation.[44] The **Medication Management** indicator provides further information.

Clinician On-Site Inspection

Our clinicians spoke with the chief nurse executive (CNE), and nursing staff and supervisors in the TTA, OHU, outpatient clinics, R&R, and medication areas. We attended well-prepared huddles in the outpatient clinic and the OHU. Nursing staff were familiar with the patient population. Clinic staff reported no backlog for the RN line at the time of our visit. One clinic collects an average of 15 to 30 sick calls daily. LVN staff serve as care coordinators in addition to their normal duties, such as performing blood pressure checks, dispensing medical supplies, and performing TB screenings. According to nursing staff, patients came to the sick call line one building at a time during the COVID-19 pandemic. Patients were also screened for COVID-19 symptoms prior to coming to the clinic for sick call appointments and wore full personal protective equipment (PPE) while in the clinic. Nursing staff reported KOP medications were handed out on third watch. The institution had a good process for managing KOP medications. The medication nurses also responded to medical emergencies in their respective yards. According to nursing staff, medication was distributed to patients in isolation buildings and those on quarantine during the COVID-19 outbreak. Furthermore, patients in quarantine buildings would come to the medication line after the patients in nonquarantine buildings had been medicated.

At the time of our on-site visit, the OHU had a patient census of 10. The OHU had a different provider scheduled daily. All staff or incarcerated person workers who entered the OHU were required to wear PPE.[45]

ASP staff reported nursing morale had been low, but was beginning to improve. Nursing morale had been affected by the challenges the COVID-19 pandemic brought to ASP, including lack of nursing staff and supply shortages. Registry staff assisted with COVID-19 monitoring. The institution provided registry staff a three-day orientation to become familiar with ASP; registry staff completed this training in addition to the training they received from CCHCS.

We also attended a COVID-19 executive strategy meeting that included discussion on vaccine updates, vaccine resources, employee vaccine clinic operations, and the reactivation of in-person visitation. ASP's leadership explained how custody, medical, and nursing staff worked together to address COVID-19 needs for patients and staff.

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44. Medication deficiencies related to nursing performance were identified in case 10.
45. PPE includes N95 masks, face shields, gowns, and gloves.

Recommendations

- Nursing leadership should provide clear guidance to nursing staff on how to appropriately document incidents, interventions, and communication with providers.

Overall
Rating
Adequate

Case Review
Rating
Adequate

Compliance
Score
(N/A)

Provider Performance

In this indicator, OIG case review clinicians evaluated the quality of care delivered by the institution's providers: physicians, physician assistants, and nurse practitioners. Our clinicians assessed the institution's providers' ability to evaluate, diagnose, and manage their patients properly. We examined provider performance across several clinical settings and programs, including sick call, emergency services, outpatient care, chronic care, specialty services, intake, transfers, hospitalizations, and specialized medical housing. We assessed provider care through case review only and performed no compliance testing for this indicator.

Results Overview

ASP providers delivered acceptable care. A large number of ASP's patients were infected during the COVID-19 pandemic. The institution had two outbreaks in 2020, one in late spring and another in the fall. ASP separated providers into two groups that alternated between helping patients on-site and over the phone. This reduced the need to reschedule patients and allowed the institution to maintain compliance with COVID-19 guidelines.[46]

Most deficiencies we identified were related to incomplete assessments and evaluations. In a few instances, the chief physician and surgeon completed the evaluations or advised another provider to consider further testing and diagnostics. This intervention improved ASP's rating in this indicator. We rated this indicator **adequate**.

Case Review Results

Our clinicians reviewed 154 provider encounters, 191 diagnostic events, and 37 specialty appointments. We identified a total of 30 deficiencies, 14 of which were significant. We also examined the care quality in 20 comprehensive case reviews. Of these 20 cases, 17 were adequate and three were inadequate.[47]

Assessment and Decision-Making

ASP providers generally made sound assessments and decisions. Case reviewers found 14 deficiencies, eight of which were significant. ASP's chief physician and surgeon collaborated with its advanced practitioners to mitigate some deficiencies in assessments and decision-making; however, some deficiencies still occurred in the cases below:

- In case 10, the provider documented that the cardiologist had commented on the patient's statin allergy when the

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46. See https://cchcs.ca.gov/covid-19-interim-guidance/.

47. Provider deficiencies occurred in cases 1,2, 3, 4, 5, 7, 8, 10, 12, 14, 15, 16, 18, 19, 20, and 21. Significant deficiencies occurred in cases 7, 10, 12, 14, 15, 18, 19, 20, and 21.

cardiologist had not.[48] The provider did not contact the specialist to determine whether the patient should be on a statin as the specialist had recommended while the patient was in the hospital.

- In case 12, the patient's test results showed low red blood cell count and elevated liver enzymes; however, the provider did not order any further diagnostics to follow up on these abnormalities. The provider also noted the patient's leg swelling and increased weight, but did not examine the patient's heart.[49]

- In case 14, the provider considered whether the patient had Bell's Palsy or a stroke, but did not perform a simple facial exam to discern between the two. Furthermore, the provider did not perform a neurological examination to assess for any deficits and did not order an urgent brain scan, thereby placing the patient at risk of a delayed diagnosis.

- In case 19, the provider evaluated the patient who had complaints of weight loss and difficulty swallowing. The provider did not consider the patient's 10 percent weight loss significant and did not evaluate the patient's swallowing complaint. The patient was later diagnosed with a progressing neurologic disorder resulting in loss of muscle control (ALS).[50]

Review of Records

ASP providers were not always careful reviewing medical records and did not always follow specialty recommendations. Six of the deficiencies we identified were related to the incomplete review of records. The case below is one example:

- In case 15, the provider did not recognize the patient's decreased renal function. The provider should have considered the patient's high systolic blood pressure unacceptable because hypertension is a major cause of kidney dysfunction.

Emergency Care

ASP providers appropriately managed patients in the TTA who had urgent and emergent conditions. However, the on-call provider did not appear to have a sense of urgency in some instances:

- In case 15, the patient had elevated blood pressures and electrocardiogram abnormalities. The on-call provider suspected the patient may have had a heart attack, but did not order cardiac medications.

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48. A statin is a cholesterol medication.
49. Leg swelling and increased weight can signify heart failure.
50. ALS stands for amyotrophic lateral sclerosis.

- In case 21, the TTA nurse notified the provider about the patient with dizziness, nausea, vomiting, and an abnormal EKG; however, the provider did not document a progress note. When the provider arrived to the TTA approximately two hours later, another provider had already taken over care and transferred the patient to the hospital.

Chronic Care

ASP providers appropriately managed patients' chronic health conditions; providers utilized nursing staff to help manage chronic medical conditions such as hypertension, diabetes, asthma, hepatitis C infection, and cardiovascular disease. We identified a minor pattern of providers not aggressively controlling patients' high blood pressures.

Specialty Services

ASP providers generally referred patients for specialty consultation when needed. However, we identified one case in which the hospital recommended a follow-up appointment with a kidney specialist for the patient even though the provider had not requested this appointment. We identified a pattern of providers not always following specialists' recommendations:

- In case 20, the cardiologist recommended a specific cholesterol goal for the high-risk cardiac patient; however, the provider did not increase the patient's statin to reduce the cholesterol.

- In case 21, the cardiologist recommended a cardiac stress test for the patient; however, the provider did not order it. This was significant because the patient had abnormalities on two previous cardiac tests.

- In case 18, the provider did not order the echocardiogram the cardiologist had recommended for the patient.

Documentation Quality

Documentation is important because it shows the providers' thought process during clinical decision-making.[51] When contacted by nurses, ASP providers did not always document the interactions. Our clinicians found seven undocumented interactions in seven of the 20 cases we reviewed. In all undocumented interactions, the provider was on call and was notified by the nurse about the patient's condition.

Provider Continuity

ASP did not have any significant problems with provider continuity in the cases we reviewed.

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51. Documentation deficiencies were identified in cases 1, 2, 3, 7, 12, 16, and 18.

Clinician On-Site Inspection

ASP had four advanced practitioners who had worked at the institution for many years. The chief medical executive (CME) and chief physician and surgeon (CP&S) had worked for ASP for over 10 years. Other providers at ASP started two months and two weeks prior to our on-site inspection, respectively.

Providers felt medical leadership was fair and approachable, and leaders praised staff for their dedication throughout the pandemic. Staff expressed enjoyment working at ASP and had good working relationships with nursing and custody staff as well.

The providers had a morning provider meeting, where they discussed overnight calls from nurses and hospitals and disseminated information from executive and CCHCS leadership. The CME and CP&S participated in the discussions and responded to providers' questions.

We inquired about the provider who ordered aspirin as needed, instead of scheduled daily. The CP&S and PIC said they had escalated the issue to headquarters and requested the listing of aspirin on the order entry be changed to show the "scheduled" aspirin order before the "as needed" aspirin order.[52]

Recommendations

We offer no specific recommendations for this indicator.

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52. *As-needed* medications, also known as PRN medications, can be taken as needed according to the directions provided.

Specialized Medical Housing

In this indicator, OIG inspectors evaluated the quality of care in the specialized medical housing units. We evaluated the performance of the medical staff in assessing, monitoring, and intervening for medically complex patients requiring close medical supervision. Our inspectors also evaluated the timeliness and quality of provider and nursing intake assessments and care plans. We assessed staff members' performance in responding promptly when patients' conditions deteriorated and looked for good communication when staff consulted with one another while providing continuity of care. Our clinicians also interpreted relevant compliance results and incorporated them into this indicator. At the time of our inspection, the ASP specialized medical housing consisted of an outpatient housing unit (OHU).

Results Overview

ASP's performance in this indicator declined compared with the Cycle 5 inspection results. The institution performed poorly in this indicator. ASP nurses often did not perform admission assessments timely. ASP patients did not have medication continuity. Nurses did not always report changes in a patient's medical condition. However, providers delivered good care in the OHU and completed patient histories and physicals within the required time frame. Nurses generally performed thorough daily patient assessments in the OHU. Considering both compliance testing and case review findings, we rated this indicator *inadequate*.

Case Review and Compliance Testing Results

In case review, our clinicians reviewed 15 OHU admissions in nine cases, which included 56 provider events and 56 nursing events.[53] Due to the volume of care that occurs in specialized medical housing units, each provider and nursing event represents up to one month of provider care and two weeks of nursing care. We identified 18 deficiencies, three of which were significant.[54]

Provider Performance

Providers delivered good care in ASP's specialized medical housing. Providers made sound medical decisions and reviewed results and consultations timely. Compliance testing showed providers completed admission histories and physicals timely (MIT 13.002, 90.0%). Case review clinicians found two deficiencies in specialized medical housing. The case below is an example:

- In case 18, the provider admitted the patient who had a heart attack to the OHU and incorrectly ordered atorvastatin and

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53. We reviewed the following cases for OHU admissions: 2, 3, 5, 12, 16, 17, 18, 46, and 47.

54. Deficiencies occurred in cases 2, 5, 10, 12, 16, 17, 18, 46, and 47. Significant deficiencies occurred in cases 12, 16, and 18.

aspirin.[55] The OHU provider self-identified the error related to the atorvastatin dose. However, the error related to the aspirin was only corrected after notice from the OIG.

Nursing Performance

Nursing performance in the OHU was mixed. Compliance testing showed OHU nurses completed less than half of the initial admission assessments within the required time frames (MIT 13.001, 40%). Out of 10 samples, nurses completed admission assessments on only four of the patients within the required time frames. For the remaining six patients, admissions assessments were completed up to two days late, and one was not completed at all. Conversely, case reviewers found OHU nurses completed admission assessments timely and most assessments were complete.

OHU nurses did not always report changes in a patient's condition. This issue occurred in cases 2, 5, 18, and in the following case:

- In case 16, the patient complained of severe groin pain. The LVN documented the complaint, but did not intervene by notifying an RN or a provider for further assessment.

Case reviewers identified incomplete documentation in cases 10, 17, 46, and 47. Incomplete documentation included not documenting quarantine rounds or the effectiveness of pain medication.

OHU nurses generally completed thorough daily patient assessments. When patients refused care, nursing staff completed refusal forms. The nurses performed wound care as ordered most of the time. ASP's OHU staff use a call bell system. When completing their rounds, nursing staff regularly documented whether the call system was within reach of the patient.

Medication Administration

ASP did not ensure medication continuity for patients admitted to the OHU. Compliance findings showed 50.0 percent for MIT 13.004. Our clinicians identified one significant deficiency:

- In case 18, After a heart attack with stent placement, the patient was discharged from the hospital and admitted to the OHU. The provider ordered Aspirin 325 mg for the patient, which was started a day late.

We found OHU patients received their medication as ordered most of the time, with the exception of the case below:

- In case 5, the provider ordered two vaccines; however, the vaccines were not administered as ordered.

55. Atorvastatin is a cholesterol medication.

Our case reviewers identified the following significant deficiency:

- In case 12, the patient was discharged from the OHU without his KOP medications (hydrochlorothiazide and lisinopril). As a result, the patient did not receive these two vital blood pressure medications until they were ordered as nurse administered medications one week after the patient was discharged from the OHU.

Clinician On-Site Inspection

The institution's OHU had 28 beds and no negative-pressure room. It is comprised of two wings with separate rooms and a dormitory. At the time of our visit, staff reported the average patient census as 10 to 12 medical patients. Patients who needed to remain NPO prior to a scheduled procedure were admitted to the OHU overnight to ensure compliance.[56]

Staffing consisted of one LVN for first watch, one RN and a CNA for second watch, and a LVN and a CNA for third watch. The OHU nurses conducted rounds each shift and the RN on second watch completed daily patient assessments. The OHU had an RN only on second watch and was staffed by LVNs on first and third watch. During first and third watch, the OHU staffed a TTA RN to complete patient admission assessments and to assess patients when their conditions changed.

A scheduled provider was assigned for second watch. During our on-site inspection, we observed a comprehensive and organized daily huddle led by the supervising RN and attended by the provider, primary RN, utilization management RN, and office technician.

Recommendations

- Nursing leadership should ensure nurses complete admission assessments for patients in the OHU within the required time frame.

- Nursing leadership should ensure nurses notify the appropriate staff members when a patient's medical condition changes.

- Nursing leadership should identify challenges in ensuring patients who are admitted into the OHU receive their medications timely upon admission and discharge. Leadership should implement remedial measures as appropriate.

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56. *NPO* means *nothing by mouth.*

Compliance Testing Results

Table 17. Specialized Medical Housing

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For OHU, CTC, and SNF: Prior to 4/2019: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice? Effective 4/2019: Did the registered nurse complete an initial assessment of the patient at the time of admission? (13.001) *	4	6	0	40.0%
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	9	1	0	90.0%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *,†	0	0	10	N/A
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	5	5	0	50.0%
For OHU and CTC only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells? (13.101) *	1	0	0	100%
For specialized health care housing (CTC, SNF, Hospice, OHU): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames? (13.102) *	N/A	N/A	N/A	N/A
Overall percentage (MIT 13): 70.0%				

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

† CCHCS changed its policies and removed mandatory minimum rounding intervals for patients located in specialized medical housing. After April 2, 2019, MIT 13.003 only applied to CTCs that still have state-mandated rounding intervals. OIG case reviewers continued to test the clinical appropriateness of provider follow-ups within specialized medical housing units through case reviews.

Source: The Office of the Inspector General medical inspection results.

Overall
Rating
Adequate

Case Review
Rating
Adequate

Compliance
Score
Adequate
(79.2%)

Specialty Services

In this indicator, OIG inspectors evaluated the quality of specialty services. The OIG clinicians focused on the institution's ability to provide needed specialty care. Our clinicians also examined specialty appointment scheduling, providers' specialty referrals, and medical staff's retrieval, review, and implementation of any specialty recommendations.

Results Overview

ASP provided satisfactory specialty services. ASP had good specialty access and staff followed up with patients after specialty consultations. Generally, providers and nurses followed through with specialty recommendations. However, there was room for improvement in the management of health information pertaining to specialty services. We rated this indicator *adequate.*

Case Review and Compliance Testing Results

In case review, our clinicians reviewed 66 events related to specialty services, including 47 specialty consultations and procedures. We identified 20 deficiencies, six of which were significant.[57]

Access to Specialty Services

ASP provided excellent access to specialists. Compliance testing showed the institution completed high-priority, medium-priority, and routine specialty appointments at a rate of 86.7 percent, 93.3 percent, and 100 percent, respectively (MIT 14.001, MIT 14.004, and MIT 14.007). However, ASP only ensured specialty access for patients who transferred into the institution with a preapproved specialty request at a rate of 25 percent (MIT 14.010). Case reviewers found no deficiencies with specialty access.

Provider Performance

ASP providers generally delivered good patient care after each specialty consultation. Compliance testing showed providers usually followed up with patients within the required time frames (MIT 1.008, 86.1%). Our case reviewers found providers generally requested the appropriate priority specialty consultation. There were two instances in which providers did not order the diagnostics the specialist requested:

- In case 18, the provider did not order the heart imaging study the specialist requested.

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57. Deficiencies in specialty services were observed in cases 5, 7, 10, 15, 18, 19, 20, and 21. Significant deficiencies were observed in cases 7, 10, 18, and 21.

- In case 21, the provider did not order the nuclear medicine stress test the cardiologist recommended. The test was essential due to the patient's abnormal electrocardiogram and exercise stress test.

Nursing Performance

ASP's nursing performance with specialty services was appropriate. Nurses properly evaluated patients returning from off-site appointments and usually messaged providers timely when providers needed to order medications or follow up with patients. Nurses completed assessments and interventions when patients returned from specialty appointments.

Health Information Management

ASP did not process specialty reports timely. Compliance testing showed variable performance in the management of health information pertaining to specialty reports with scores of 64.3 percent, 85.7 percent, and 46.7 percent for routine, medium, and high-priority referrals, respectively (MIT 14.008, MIT 14.005, and MIT 14.002). Reports were generally scanned into the EHRS timely (MIT 4.002, 83.3%). Our clinicians found a pattern of late retrievals and provider endorsements outside policy time frames:

- In case 7, medical staff did not retrieve the off-site gastroenterology consultation or scan it into the EHRS.

- In case 21, the institution was unable to retrieve the echocardiogram report until 16 days after the procedure. In the same case, the institution was unable to retrieve the stress test until 15 days later. ASP contacted the specialist twice to get the stress test report.

Clinician On-Site Inspection

We spoke with nurse managers, supervisors, providers, and utilization nursing staff about specialty referral management. Providers had no issues obtaining specialty services within their requested time frames. According to ASP, some specialists closed their clinics during the COVID-19 pandemic. In response, staff reviewed appointments to determine whether patients could be rescheduled.

Recommendations

- Medical leadership should review the causes of untimely provider reviews of specialty reports and implement remedial measures as appropriate

- Medical and nursing leadership should ensure patients transferring into ASP receive their previously scheduled specialty appointments within the required time frames.

Compliance Testing Results

Table 18. Specialty Services

Compliance Questions	Yes	No	N/A	Yes %
		Scored Answer		
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	13	2	0	86.7%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	7	8	0	46.7%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	5	0	10	100%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004) *	14	1	0	93.3%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	12	2	1	85.7%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	5	1	9	83.3%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	15	0	0	100%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	9	5	1	64.3%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	9	0	6	100%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010) *	1	3	0	25.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	18	2	0	90.0%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	15	5	0	75.0%
Overall percentage (MIT 14): **79.2%**				

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Table 19. Other Tests Related to Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *, †	37	6	2	86.1%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	25	5	15	83.3%

* The OIG clinicians considered these compliance tests along with their own case review findings when determining the quality rating for this indicator.

† CCHCS changed its specialty policies in April 2019, removing the requirement for primary care physician follow-up visits following most specialty services. As a result, we test 1.008 only for high-priority specialty services or when the staff orders PCP or PC RN follow-ups. The OIG continues to test the clinical appropriateness of specialty follow-ups through its case review testing.

Source: The Office of the Inspector General medical inspection results.

Overall Rating
Adequate

Case Review Rating
(N/A)

Compliance Score
Adequate
(80.8%)

Administrative Operations

In this indicator, OIG compliance inspectors evaluated health care administrative processes. Our inspectors examined the timeliness of the medical grievance process and checked whether the institution followed reporting requirements for adverse or sentinel events and patient deaths. Inspectors checked whether the Emergency Medical Response Review Committee (EMRRC) met and reviewed incident packages. We reviewed and determined whether the institution conducted the required emergency response drills. Inspectors also assessed whether the Quality Management Committee (QMC) met regularly and addressed program performance adequately. In addition, the inspectors examined if the institution provided training and job performance reviews for its employees. They checked whether staff possessed current, valid professional licenses, certifications, and credentials. The OIG rated this indicator solely based on the compliance score, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

Because none of the tests in this indicator affected clinical patient care directly (it is a secondary indicator), the OIG did not consider this indicator's rating when determining the institution's overall quality rating.

Results Overview

ASP had adequate performance in this indicator. The institution scored well in most applicable tests; however, a few areas had room for improvement. The institution conducted medical emergency response drills with incomplete documentation and had no evidence custody participated in the drill. The physician managers did not always complete annual performance appraisals timely. Staff did not have a local system in place to track and monitor cardiopulmonary resuscitation, basic life support, and advanced cardiac life support certifications for providers. These findings are set forth in Table 20 on the next page. We rated this indicator *adequate*.

Nonscored Results

We obtained CCHCS Death Review Committee (DRC) reporting data. Nine unexpected (Level 1) deaths occurred during our review period. The DRC must complete its death review summary report within 60 calendar days of the death. When the DRC completes the death review summary report, it must submit the report to the institution's CEO within seven calendar days of completion. In our inspection, we found the DRC did not complete four death review reports timely; the DRC reports were completed one to 28 days late and submitted to the institution's CEO 42 to 89 days late (MIT 15.998).

Recommendations

The OIG offers no specific recommendations for this indicator.

Table 20. Administrative Operations

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001) *	N/A	N/A	N/A	N/A
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	9	3	0	75.0%
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent meet quarterly and discuss local operating procedures and any applicable policies? (15.004)	N/A	N/A	N/A	N/A
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	0	3	0	0
Did the responses to medical grievances address all of the inmates' appealed issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial inmate death reports to the CCHCS Death Review Unit on time? (15.103)	9	0	0	100%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	10	0	0	100%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	4	5	0	44.4%
Did the providers maintain valid state medical licenses? (15.106)	10	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	1	1	1	50.0%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	5	0	2	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates? (15.109)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	1	0	0	100%
Did the CCHCS Death Review Committee process death review reports timely? (15.998)	This is a nonscored test. Please refer to the discussion in this indicator.			
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This is a nonscored test. Please refer to Table 4 for CCHCS-provided staffing information.			
Overall percentage (MIT 15): 80.8%				

* Effective March 2021, this test was for informational purposes only.

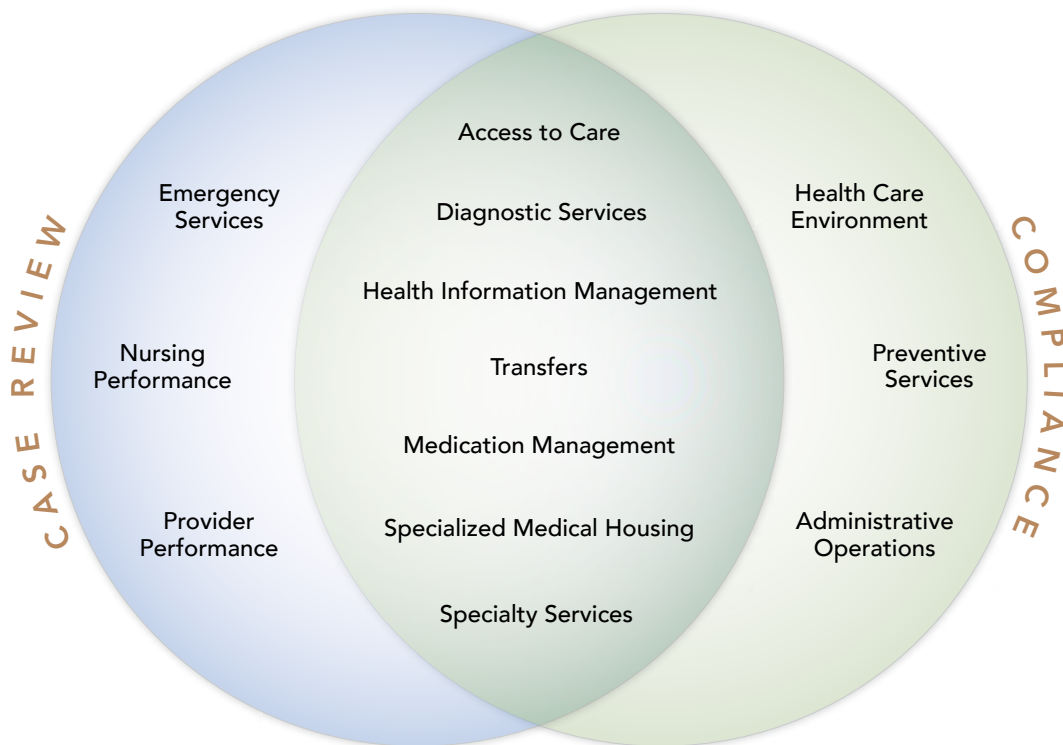Source: The Office of the Inspector General medical inspection results.

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Appendix A: Methodology

In designing the medical inspection program, the OIG met with stakeholders to review CCHCS policies and procedures, relevant court orders, and guidance developed by the American Correctional Association. We also reviewed professional literature on correctional medical care; reviewed standardized performance measures used by the health care industry; consulted with clinical experts; and met with stakeholders from the court, the receiver's office, the department, the Office of the Attorney General, and the Prison Law Office to discuss the nature and scope of our inspection program. With input from these stakeholders, the OIG developed a medical inspection program that evaluates the delivery of medical care by combining clinical case reviews of patient files, objective tests of compliance with policies and procedures, and an analysis of outcomes for certain population-based metrics.

We rate each of the quality indicators applicable to the institution under inspection based on case reviews conducted by our clinicians or compliance tests conducted by our registered nurses. Figure A–1 below depicts the intersection of case review and compliance.

Figure A–1. Inspection Indicator Review Distribution for ASP

CASE REVIEW

COMPLIANCE

Access to Care

Emergency Services

Health Care Environment

Diagnostic Services

Health Information Management

Nursing Performance

Transfers

Preventive Services

Medication Management

Provider Performance

Specialized Medical Housing

Administrative Operations

Specialty Services

Source: The Office of the Inspector General medical inspection results.

Case Reviews

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in the Cycle 6 medical inspections. Below, Table A–1 provides important definitions that describe this process.

Table A–1. Case Review Definitions

Case, Sample, or Patient	The medical care provided to one patient over a specific period, which can comprise detailed or focused case reviews.
Comprehensive Case Review	A review that includes all aspects of one patient's medical care assessed over a six-month period. This review allows the OIG clinicians to examine many areas of health care delivery, such as access to care, diagnostic services, health information management, and specialty services.
Focused Case Review	A review that focuses on one specific aspect of medical care. This review tends to concentrate on a singular facet of patient care, such as the sick call process or the institution's emergency medical response.
Event	A direct or indirect interaction between the patient and the health care system. Examples of direct interactions include provider encounters and nurse encounters. An example of an indirect interaction includes a provider reviewing a diagnostic test and placing additional orders.
Case Review Deficiency	A medical error in procedure or in clinical judgment. Both procedural and clinical judgment errors can result in policy noncompliance, elevated risk of patient harm, or both.
Adverse Event	An event that caused harm to the patient.

The OIG eliminates case review selection bias by sampling using a rigid methodology. No case reviewer selects the samples he or she reviews. Because the case reviewers are excluded from sample selection, there is no possibility of selection bias. Instead, nonclinician analysts use a standardized sampling methodology to select most of the case review samples. A randomizer is used when applicable.

For most basic institutions, the OIG samples 20 comprehensive physician review cases. For institutions with larger high-risk populations, 25 cases are sampled. For the California Health Care Facility, 30 cases are sampled.

Case Review Sampling Methodology

We obtain a substantial amount of health care data from the inspected institution and from CCHCS. Our analysts then apply filters to identify clinically complex patients with the highest need for medical services. These filters include patients classified by CCHCS with high medical risk, patients requiring hospitalization or emergency medical services, patients arriving from a county jail, patients transferring to and from other departmental institutions, patients with uncontrolled diabetes or uncontrolled anticoagulation levels, patients requiring specialty services or who died or experienced a sentinel event (unexpected occurrences resulting in high risk of, or actual, death or serious injury), patients requiring specialized medical housing placement, patients requesting medical care through the sick call process, and patients requiring prenatal or postpartum care.

After applying filters, analysts follow a standardized protocol and select samples for clinicians to review. Samples are obtained per the case review methodology shared with stakeholders in prior cycles. Our physician and nurse reviewers test the samples by performing comprehensive or focused case reviews.

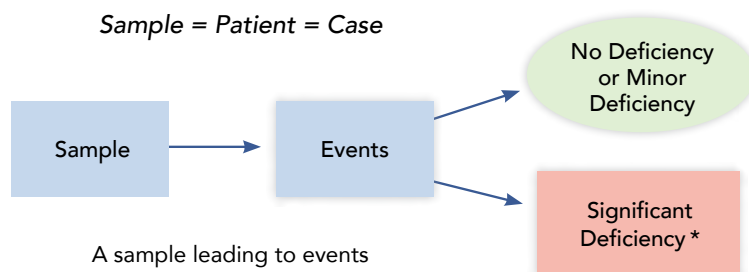## Case Review Testing Methodology

An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review *events*. Our clinicians also record medical errors, which we refer to as case review *deficiencies*.

Deficiencies can be minor or significant, depending on the severity of the deficiency. If a deficiency caused serious patient harm, we classify the error as an *adverse event*. On the next page, Figure A–2 depicts the scenarios that can lead to these different events.

After the clinician inspectors review all the cases, they analyze the deficiencies, then summarize their findings in one or more of the health care indicators in this report.
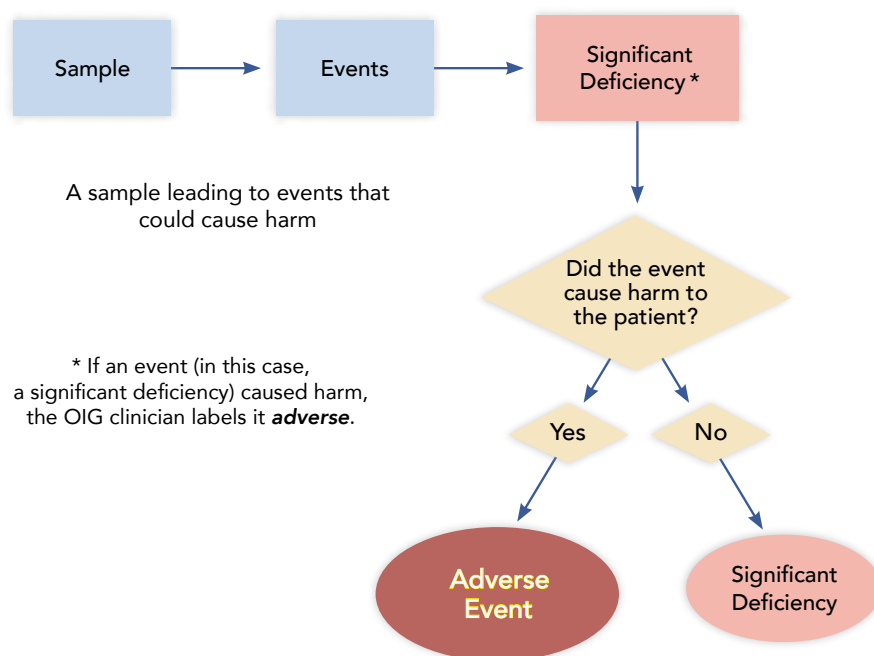
Figure A–2. Case Review Testing

The OIG clinicians examine the chosen samples, performing either a **comprehensive case review** or a **focused case review**, to determine the events that occurred.

Sample = Patient = Case

```
                                      No Deficiency
                                      or Minor
                                      Deficiency

  Sample   →    Events   →

       A sample leading to events    Significant
                                     Deficiency *
```

Deficiencies

Not all events lead to deficiencies (medical errors); however, if errors did occur, then the OIG clinicians determine whether any were **adverse**.

```
  Sample   →    Events   →   Significant
                             Deficiency *

     A sample leading to events that
         could cause harm
                                  Did the event
                                  cause harm to
                                  the patient?

   * If an event (in this case,
 a significant deficiency) caused harm,      Yes       No
   the OIG clinician labels it adverse.

                               Adverse          Significant
                               Event            Deficiency
```

Source: The Office of the Inspector General medical inspection analysis.

Compliance Testing

Compliance Sampling Methodology

Our analysts identify samples for both our case review inspectors and compliance inspectors. Analysts follow a detailed selection methodology. For most compliance questions, we use sample sizes of approximately 25 to 30. Figure A–3 below depicts the relationships and activities of this process.

Figure A–3. Compliance Sampling Methodology
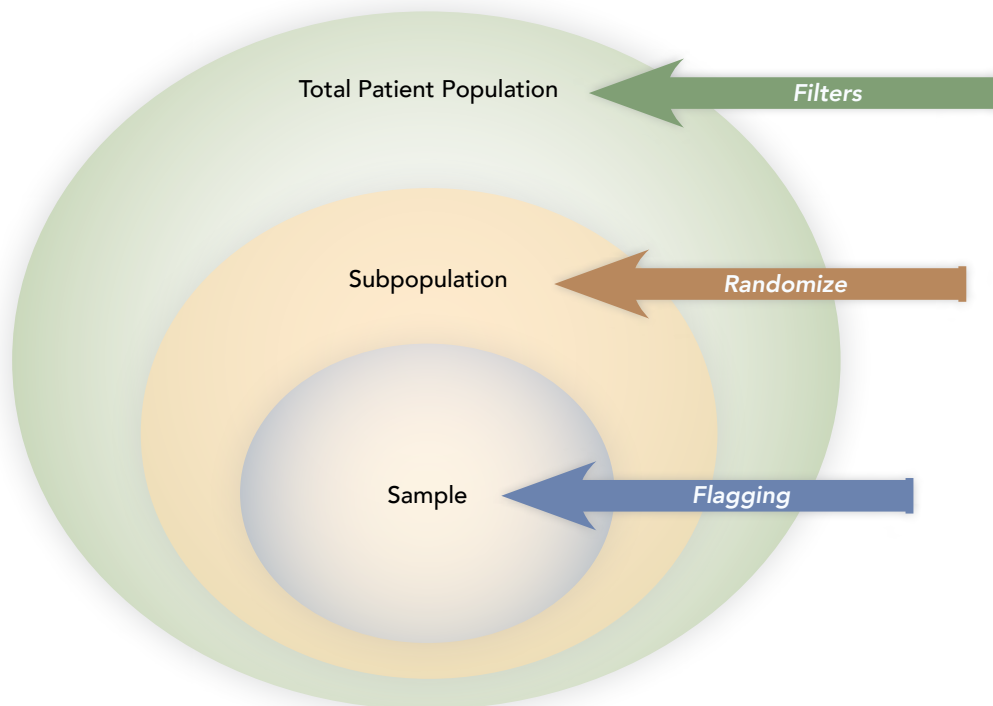
Total Patient Population

Filters

Subpopulation

Randomize

Sample

Flagging

Source: The Office of the Inspector General medical inspection analysis.

Compliance Testing Methodology

Our inspectors answer a set of predefined medical inspection tool (MIT) questions to determine the institution's compliance with CCHCS policies and procedures. Our nurse inspectors assign a *Yes* or a *No* answer to each scored question.

OIG headquarters nurse inspectors review medical records to obtain information, allowing them to answer most of the MIT questions. Our regional nurses visit and inspect each institution. They interview health care staff, observe medical processes, test the facilities and clinics, review employee records, logs, medical grievances, death reports, and other documents, and also obtain information regarding plant infrastructure and local operating procedures.

Scoring Methodology

Our compliance team calculates the percentage of all *Yes* answers for each of the questions applicable to a particular indicator, then averages the scores. The OIG continues to rate these indicators based on the average compliance score using the following descriptors: *proficient* (85.0 percent or greater), *adequate* (between 84.9 percent and 75.0 percent), or *inadequate* (less than 75.0 percent).

Indicator Ratings and the Overall Medical Quality Rating

To reach an overall quality rating, our inspectors collaborate and examine all the inspection findings. We consider the case review and the compliance testing results for each indicator. After considering all the findings, our inspectors reach consensus on an overall rating for the institution.

Appendix B: Case Review Data

Table B–1. ASP Case Review Sample Sets

Sample Set	Total
CTC/OHU	2
Death Review/Sentinel Events	2
Diabetes	3
Emergency Services – CPR	1
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	18
Specialty Services	3
	47

Table B–2. ASP Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	2
Arthritis/Degenerative Joint Disease	3
Asthma	4
COPD	2
Cardiovascular Disease	3
Chronic Pain	4
Cirrhosis/End-Stage Liver Disease	1
Coccidioidomycosis	1
COVID-19	10
Diabetes	6
Gastroesophageal Reflux Disease	5
Hepatitis C	8
Hyperlipidemia	15
Hypertension	16
Mental Health	12
Migraine Headaches	1
Seizure Disorder	1
Sleep Apnea	4
Thyroid Disease	5
	103

Table B–3. ASP Case Review Events by Program

Diagnosis	Total
Diagnostic Services	201
Emergency Care	46
Hospitalization	30
Intrasystem Transfers In	5
Intrasystem Transfers Out	4
Not Specified	2
Outpatient Care	355
Specialized Medical Housing	141
Specialty Services	66
	850

Table B–4. ASP Case Review Sample Summary

MD Reviews Detailed	20
MD Reviews Focused	3
RN Reviews Detailed	16
RN Reviews Focused	25
Total Reviews	64
Total Unique Cases	47
Overlapping Reviews (MD & RN)	17

Appendix C: Compliance Sampling Methodology

Avenal State Prison

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	30	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	5	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	45	OIG Q: 14.001, 14.004 & 14.007	• See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	• Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	• Appointment date (90 days–9 months) • Randomize • Abnormal
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	2	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.010–012	Pathology	10	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	30	OIG Qs: 1.004	• Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	5	OIG Q: 4.005	• Community hospital discharge documents • First 20 IPs selected
MIT 4.004	Scanning Accuracy	24	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.005	Returns From Community Hospital	5	CADDIS off-site Admissions	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
Health Care Environment				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	10	OIG inspector on-site review	• Identify and inspect all on-site clinical areas.
Transfers				
MITs 6.001–003	Intrasystem Transfers	25	SOMS	• Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	4	OIG inspector on-site review	• R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	See **Access to Care** • At least one condition per patient—any risk level • Randomize
MIT 7.002	New Medication Orders	25	Master Registry	• Rx count • Randomize • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	5	OIG Q: 4.005	• See **Health Information Management** (Medical Records) (returns from community hospital)
MIT 7.004	RC Arrivals—Medication Orders	N/A at this institution	OIG Q: 12.001	• See **Reception Center**
MIT 7.005	Intrafacility Moves	25	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • Randomize
MIT 7.006	En Route	9	SOMS	• Date of transfer (2–8 months) • Sending institution (another departmental facility) • Randomize • NA/DOT meds
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	• Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	1	OIG inspector on-site review	• Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	19	Medication error reports	• All medication error reports with Level 4 or higher • Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Restricted Unit KOP Medications	N/A at this institution	On-site active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in restricted units

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Prenatal and Postpartum Care				
MITs 8.001–007	Recent Deliveries	N/A at this institution	OB Roster	• Delivery date (2–12 months) • Most recent deliveries (within date range)
	Pregnant Arrivals	N/A at this institution	OB Roster	• Arrival date (2–12 months) • Earliest arrivals (within date range)
Preventive Services				
MITs 9.001–002	TB Medications	4	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize
MIT 9.003	TB Evaluation, Annual Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth month • Randomize
MIT 9.004	Influenza Vaccinations	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Randomize • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • Randomize
MIT 9.006	Mammogram	N/A at this institution	SOMS	• Arrival date (at least 2 yrs. prior to inspection) • Date of birth (age 52–74) • Randomize
MIT 9.007	Pap Smear	N/A at this institution	SOMS	• Arrival date (at least three yrs. prior to inspection) • Date of birth (age 24–53) • Randomize
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)
MIT 9.009	Valley Fever (number will vary)	17	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001–008	RC	N/A at this institution	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing				
MITs 13.001–004	Specialized Health Care Housing Unit	10	CADDIS	• Admit date (2–8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MIT 13.101–102	Call Buttons	All	OIG inspector on-site review	• Specialized Health Care Housing • Review by location
Specialty Services				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	15	Specialty Service Appointments	• Approval date (3–9 months) • • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	Specialty Service Appointments	• Approval date (3–9 months) • • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize
MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	Specialty Service Appointments	• Approval date (3–9 months) • • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
MIT 14.010	Specialty Services Arrivals	4	Specialty Services Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	20	InterQual	• Review date (3–9 months) • Randomize
		N/A	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize
Administrative Operations				
MIT 15.001	Adverse/sentinel events (ASE)	N/A at this institution	Adverse/sentinel events report	• Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.004	LGB	N/A at this institution	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	• Medical grievances closed (6 months)
MIT 15.103	Death Reports	9	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	• On duty one or more years • Nurse administers medications • Randomize
MIT 15.105	Provider Annual Evaluation Packets	9	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	10	Current provider listing (at start of inspection)	• Review all
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	• All staff ◦ Providers (ACLS) ◦ Nursing (BLS/CPR) • Custody (CPR/BLS)
MIT 15.108	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	• All required licenses and certifications

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 15.109	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.110	Nursing Staff New Employee Orientations	All	Nursing staff training logs	• New employees (hired within last 12 months)
MIT 15.998	Death Review Committee	9	OIG summary log: deaths	• Between 35 business days & 12 months prior • California Correctional Health Care Services death reviews

California Correctional Health Care Services' Response

October 22, 2021

Roy Wesley, Inspector General
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Mr. Wesley:

The Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for Avenal State Prison (ASP) conducted from June to November 2020. California Correctional Health Care Services (CCHCS) acknowledges the OIG findings.

Thank you for preparing the report. Your efforts have advanced our mutual objective of ensuring transparency and accountability in CCHCS operations. If you have any questions or concerns, please contact me at (916) 691-3999.

Sincerely,

Erin Hoppin
Digitally signed by Erin Hoppin
Date: 2021.10.22
12:22:05 -07'00'

Erin Hoppin
Associate Director
Risk Management Branch
California Correctional Health Care Services

cc: Clark Kelso, Receiver
     Richard Kirkland, Chief Deputy Receiver
     Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
     Directors, CCHCS
     Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
     Jackie Clark, Deputy Director (A), Institution Operations, CCHCS
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     Barbara Barney-Knox, R.N., Deputy Director, Nursing Services, CCHCS
     Annette Lambert, Deputy Director, Quality Management, CCHCS
     Regional Health Care Executive, Region III, CCHCS
     Regional Deputy Medical Executive, Region III, CCHCS
     Regional Nursing Executive, Region III, CCHCS
     Chief Executive Officer, ASP
     Katherine Tebrock, Chief Assistant Inspector General, OIG
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Cycle 6
Medical Inspection Report

for

Avenal State Prison

OFFICE *of the*
INSPECTOR GENERAL

Roy W. Wesley
Inspector General

Bryan B. Beyer
Chief Deputy Inspector General

STATE *of* CALIFORNIA
November 2021

OIG